

Mail completed forms to:
 Department of Labor and Industries
 Crime Victims Compensation Program
 PO Box 44520
 Olympia WA 98504-4520



STATEMENT FOR HOME NURSING SERVICES

Instructions on next page

Claimant Information (Please print)

Name (Last, First, Middle Initial)			Claim No.
Home address (not PO Box)		Apt #	Date of injury
City	State	ZIP	Social Security No. (for ID only)
			Phone no.

Provider Information (Please print)

Provider name		L&I provider number
Address		NPI
City	State	Federal Tax ID/Employer ID Number
Name of referring physician or other source		Phone no.
Referring provider number/NPI		Referral ID

Billing Information

Is this bill to reimburse the claimant? Yes (Receipt and signature required) No

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Units	Hourly/Day rate	Charges
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
											Total Charge \$

Claimant Signature:

These expenses are related to my crime victims' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Signature (Required for claimant reimbursement) _____ Date _____

Signature _____ Date _____

Instructions for completing the Statement for Miscellaneous Services:

Worker Information:

Claim number	Give the claimant's claim number.
Name	Write the claimant's legal name in the last, first, middle initial format.
Date of injury	Date of injury.
Home address	Give the most current physical address of the claimant.
Social Security Number	Write the claimant's Social Security Number. Used to verify claim number only.
Phone number	Write the claimant's phone number.

Provider Information:

L&I provider number	Give the provider's L&I provider number.
Provider name	Write the provider's name as registered with L&I.
Provider address	Write the provider's physical address.
NPI	Give the provider's NPI.
Federal Tax ID	Write the Federal Tax ID (EIN) for the billing provider. This must match the EIN on file with the agency.
Phone number	Give the phone number where the agency can call if there any questions about your bill.
Name of referring physician or other source	Write the name of the referring physician or other source for the services provided.
Referring provider number/NPI	Write the L&I provider number or NPI of the referring provider
Referral ID	Write the referral ID number.

Bill Information:

Is this bill to reimburse the claimant?	Check the appropriate box. If this bill is to reimburse a claimant, receipts are required. Send copies of your receipts. Receipts must be itemized and legible. No credit card slips.
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Use one line for each service provided. Complete each applicable field.

From date of service	Starting date of service.
To date of service	Ending date of service.
POS	Place of service. See the list below for the appropriate two-digit code.
Proc Code	Procedure code.
Mod	Modifier code if applicable.
Diagnosis	Diagnosis code. Enter the primary diagnosis code for each service.
Description	Give a brief description of services provided.
Units	Enter the number of units for service.
Charges	Enter the charge for each service provided.
Total charges	Enter the total charges for your bill.

Place of Service Codes

- | | | |
|---|--|--|
| 03. School | 22. Outpatient hospital | 53. Community mental health ctr |
| 04. Homeless shelter | 23. Emergency room - hospital | 54. Intermediate care facility/mentally retarded |
| 05. Indian Health Service free-standing facility | 24. Ambulatory surgical center | 55. Residential substance abuse trmt center |
| 06. Indian Health Service provider-based facility | 25. Birthing center | 56. Psychiatric residential trmt ctr |
| 07. Tribal 638 free-standing facility | 26. Military treatment facility | 57. Non-residential substance abuse treatment center |
| 08. Tribal 638 provider-based facility | 31. Skilled nursing facility | 60. Mass immunization center |
| 09. Correctional facility | 32. Nursing facility | 61. Comprehensive inpatient rehabilitation facility |
| 11. Office | 33. Custodial care facility | 62. Comprehensive outpatient |
| 12. Patient's home | 34. Hospice | 65. End stage renal disease treatment facility |
| 14. Group home | 41. Ambulance - land | 71. State or local public health clinic |
| 15. Mobile unit | 42. Ambulance - air or water | 72. Rural health clinic |
| 16. Temporary lodging | 49. Independent clinic rehabilitation facility | 81. Independent laboratory |
| 17. Walk-in retail health center | 50. Federally qualified hlth ctr | 99. Other unlisted facility |
| 20. Urgent care facility | 51. Inpatient psychiatric facility | |
| 21. Inpatient hospital | 52. Psychiatric facility partial hospitalization | |