

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



CRIME VICTIM STATEMENT FOR MISCELLANEOUS SERVICES

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Claimant Information (Please print)

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

Provider Information (Please print)

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

Billing Information

For glasses, is the old Rx available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the claimant? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
For inpatient services: Date admitted: _____ Date discharged: _____	

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Dx	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$

Claimant Signature:

These expenses are related to my workers' 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 worker reimbursement) _____ Date _____

Signature _____ Date _____

Instructions for completing the Crime Victim Statement for Miscellaneous Services:

Type of Service:

Check the appropriate box for the type of service for which you are billing. If your type of service is not listed, check the "Other" box and list the type of service you provided.

Worker Information:

Claim number	Give the 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.
For glasses, is the old Rx available?	Check the appropriate box.
For inpatient services	Write date of admission and the date of discharge in the mm/dd/yy format.

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.
Dx	Diagnosis code. Enter the primary diagnosis code for each service.
Description	Give a brief description of services provided.
Dental tooth number	Tooth number dental services were provided for.
Home nursing	Give the number of hours you are billing for. Give your hourly or daily rate for your services.
Charges	Enter the charge for each service provided.
Units	Enter the number of units for service.

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 | |