Washington State D

STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
PO Box 44261 Olympia, Washington 98504-4261

BILLING INSTRUCTIONS
STATEMENT FOR MISCELLANEOUS SERVICES
BILL FORM
F245-072-000

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Advanced Registered Nurse Practitioner,
Certified Registered Nurse Anesthetist, Registered Nurse,
Dental Services, Durable Medical Equipment, Drug & Alcohol Treatment,
Hearing Aid Fitter/dispensers, Interpreter Services, Licensed Massage Therapy,
Lodging/Meal Services, Nurse Case Management, Obesity Treatment,
Occupational Therapy, Optometry/Optician Services,
Physical Therapy (voc svcs), Vocational Rehabilitation Services

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PROVIDER ACCOUNT REQUIREMENTS

A provider must have an active L&I provider account number in order to treat Washington workers and receive payment for medical services. . Once the L&I provider account number is established, and the federally-issued National Provider Identifier (NPI) is registered with L&I, either number can be used on bills and correspondence submitted to the insurer.
Provider Accounts Website – http://www.lni.wa.gov/ClaimsIns/Providers/Becoming/default.asp
Provider Accounts phone – 360-902-5140

The L&I website offers many resources to providers. Go to http://www.lni.wa.gov/

PROVIDER SPECIFIC INSTRUCTIONS

Advanced Registered Nurse Practitioner
Certified Registered Nurse Anesthetist
Registered Nurse

Advanced Registered Nurse Practitioner
Refer to WAC 296-23-240 for licensed nursing rules and WAC 296-23-245 for licensed nursing billing instructions.
ARNP services will be paid at a maximum of 90% of the allowed fee that would be paid to a physician.
See WAC 296-23-241 for ARNP performing the functions of an attending provider.

Certified Registered Nurse Anesthetists
CRNA services are paid at a maximum of 90% of the allowed fee that would be paid to a physician. The only modifiers that are valid for CRNAs are -QX and -QZ.

Refer to WAC 296-23-240 for licensed nursing rules and WAC 296-23-245 for licensed nursing billing instructions.
For more detailed billing instructions, including examples of how to submit bills request a CD tool kit from Provider Accounts at 1-800-848-0811.
Visit our website at http://www.lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/default.asp

CRNA services should not be reported on the same CMS-1500 form used to report anesthesiologist services; this applies to solo CRNA services as well as team care.
Please also refer to the “Professional Services” section of the current fee schedule.

Registered Nurse as Surgical Assistants
Licensed registered nurses may be paid to perform surgical assistant services if they submit the following documents to L&I along with their completed provider application:

- A photocopy of her/his valid and current registered nurse license, and
- A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Payment for these services is 90% of the allowed fee that would be paid to an assistant surgeon.
For further information please refer to WAC 296-23-240 & WAC 296-23-245.

Dental Services

Dental providers licensed in the state in which they practice may be paid for performing dental services (WAC 296-20-110 and WAC 296-23-160).

Authorization and treatment plan requirements
Procedures requiring prior authorization are noted in the fee schedule by a Y in the "Prior Auth" column.

You may also use the Billing Code ID search box on our website:
http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2010/default.asp

Contact the following for procedures requiring prior authorization:

- L&I claim manager for state workers' compensation claims and CVC claims
- Self-insured employer (SIE) or their third party administrator (TPA): information go to: http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

Only claim managers can authorize dental services for State Fund workers' compensation claims and CVC claims.

Claim services requiring prior authorization require a treatment plan. The dentist should outline the extent of the dental injury and the treatment plan (WAC 296-20-110)

The treatment plan and/or alternative treatment plan must be completed and submitted before authorization can be granted. If other providers are performing services, it will also be necessary for them to submit treatment plans. A 6-point per tooth periodontal chart and/or X-rays may be requested.

Mail State Fund **treatment plans** to:

Department of Labor & Industries

PO Box 44291

Olympia, Washington 98504-4291

State Fund treatment plans (**not billing** info) may be faxed to:

(360) 902-4567

Mail CVC claim **treatment plans** to:

Department of Labor & Industries

PO Box 44520

Olympia, Washington 98504-4520

Mail self-insured treatment plans to the SIE/TPA.
http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

Copies of the HCPCS Level I and II codes may be purchased from:

The Superintendent of Documents
United States Government Printing Office
Washington DC 20402

Or downloaded from http://www.cms.hhs.gov/HCPCSReleaseCodeSets/

Please refer to the "Professional Services" section of the current fee schedule.

DME Services

Pharmacies and DME providers must bill their "usual and customary" charge for supplies and equipment with appropriate HCPCS and local codes. Delivery charges, shipping and handling, tax, and fitting fees are **not payable separately**. Include these charges in the total charge for the supply. See WAC 296-20-1102 for information on the rental or purchase of DME.

A modifier is always required on all HCPCS codes that are used to purchase or rent DME.
–NU for a new purchase or
–RR for a rental.

The HCPCS Section of the Professional Services Fee Schedule lists the HCPCS E codes and the HCPCS K codes that require either –NU or –RR. Look in the HCPCS/CPT® code column of the fee schedule for the appropriate modifier. There is also a column in fee schedule that designates the HCPCS code as requiring prior authorization. There is no need to obtain prior authorization if the code does not require it.

DME codes fall into one of 3 groups relative to modifier usage. DME that is:

- Only purchased (only –NU modifier allowed).
- Only rented (only –RR modifier allowed).
- Either purchased or rented (either –NU or –RR modifier allowed).

Bills submitted without the correct modifier will be denied payment. Providers may continue to use other modifiers, for example –LT,–RT etc., in conjunction with the mandatory modifiers if appropriate (up to 4 modifiers may be used on any 1 HCPCS code).

Exception: HCPCS Codes

- K0739: Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes does not require a modifier.
- K0740: Repair or no routine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes.

L&I **will not** purchase used equipment.

Self-insured employers **may purchase** used equipment.

Rental payments will not exceed 12 months. At the 12th month of rental, the equipment is ***owned by the worker***. The insurer may review rental payments at 6 months and decide to purchase the equipment at that time. The purchased DME belongs to the worker. The maximum allowable rental fee is based on a per month period. Rental of 1 month or less is equal to 1 unit of service.

Exception: HCPCS Codes

- E0935 and E0936: continuous passive motion exercise device for use on knee only and continuous passive motion exercise device for use other than knee respectively are rented on a per diem basis up to 14 days with 1 unit of service equaling 1 day. Contact the claims manager for rental beyond 14 days. E1800-E1818, E1825-E1840, extension/flexion device. These devices are rented for 1 month. If needed beyond 1 month, a claims manager's authorization is required.

DME, Miscellaneous, E1399

HCPCS code E1399 will be paid by report.

- E1399 is payable only for DME that doesn't have a valid HCPCS code assigned.
- All bills for E1399 items must have either the NU or RR modifier.
- A description must be on the paper bill or in the remarks section of the electronic bill.
- The item must be appropriate and relative to the injury or type of treatment being received.

During the authorized rental period, the DME belongs to the provider. When the equipment is no longer authorized, the DME will be returned to the provider. If the unauthorized DME is not returned to the provider within 30 days, the provider can bill the worker for charges related to DME rental, purchase and supplies that accrue after DME authorization is denied by the insurer.

Some DME requires a prior authorization. Prior authorization for L&I claims can be obtained by calling the claim manager or Provider Hotline. The Provider Hotline can be reached at 1-800-848-0811 or from Olympia 902-6500.

Fee schedule payments for stationary oxygen system rentals are all-inclusive. One monthly fee is paid for a stationary oxygen system. This fee includes payment for the equipment, contents (if applicable), necessary maintenance and accessories furnished during a rental month.

If the worker owns a stationary oxygen system, payment will be made for contents of the stationary gaseous (E0441) or liquid (E0442) system.

Fee schedule payments for portable oxygen system rentals are all-inclusive. One monthly fee is paid for a portable oxygen system. This fee includes payment for the equipment, contents, necessary maintenance and accessories furnished during a rental month.

If the worker owns a portable oxygen system, payment may be made for the portable contents of the gaseous (E0443) or liquid (E0444) portable system.

The fee for oxygen contents (stationary or portable) is billed once a month, not daily or weekly. One unit of service is equal to 1 month of rental.

Repair, non-routine service and maintenance on purchased equipment that is out of warranty will be paid by report.

In those cases where damage to a piece of DME is due to worker:

- Abuse,
- Neglect or
- Misuse

The repair or replacement is the responsibility of the worker. Replacement of lost or stolen DME is also the responsibility of the worker.

K0739 and K0740 should be billed per each 15 minutes. Each 15 minutes should be represented by one unit of service in the ‘Units’ field.

> **For example**, 45 minutes for a repair or non-routine service of equipment requiring a skilled technician would be billed with 3 units of service.

A copy of the original warranty is required on each repair service completed. For State Fund claims, send a copy to:

Department of Labor and Industries

PO Box 44291

Olympia, WA 98504-4291

Write the claim number in the upper right hand corner of the warranty document. Payment will be denied if:

- No original warranty document is received
- The item is still under warranty

For further information regarding DME services, refer the “Professional Services” section of the current *Medical Aid Rules and Fee Schedule.*

Drug & Alcohol Treatment

H0001	Assessment	H0011	Acute Detoxification
H0002	Screening	H0012	Sub-Acute Detoxification
H0003	Screening; Lab Analysis	H0013	Acute Detoxification
H0004	Individual Counseling	H0014	Ambulatory Detoxification
H0005	Group Counseling	H0015	Intensive Outpatient
H0006	Case Mgmt	H0017	Residential
H0007	Crisis Intervention	H0018	Short-Term Residential
H0008	Sub-Acute Detoxification	H0019	Long-Term Residential
H0009	Acute Detoxification	H0020	Methadone Administration
H0010	Sub-Acute Detoxification		

Hearing Aid Services

The following policies and requirements apply to all hearing aid services and devices except for CPT® codes.

The insurer will authorize hearing aids only when prescribed or recommended by a physician or ARNP and the claim for hearing loss has been allowed. State Fund claim managers use the information outlined below to decide whether an individual worker has a valid work-related hearing loss (an SIE/TPA may use these or similar forms to gather information).

- Report of Accident
- Occupational Disease Employment History Hearing Loss (F262-013-000; F262-013-111 continuation)
- Occupational Hearing Loss Questionnaire (F262-016-000)
- Valid audiogram
- Medical report
- Hearing Services Worker Information (F245-049-000)
- Authorization to Release Information (F262-005-000)

The insurer **does not pay** any provider or worker to fill out the Employment History Hearing Loss or Occupational Hearing Loss Questionnaire.

Physicians or ARNPs may be paid for a narrative assessment of work-relatedness to the hearing loss condition. Refer to the *Attending Doctors Handbook* table on Other Miscellaneous Codes and Descriptions.

The insurer **will pay** for the cost of battery replacement for the life of an authorized hearing aid. No more than 1 box of batteries (40) will be paid within each 90-day period.

> **NOTE:** Sending workers batteries that they have not requested and for which they do not have an immediate need is in violation of L&I's rules and payment policies.

The insurer **will not pay** for any repairs including parts and labor within the manufacturer's warranty period.

The insurer will not pay for the reprogramming of hearing aids.

Parts and supplies **must be billed** and **will be paid** at acquisition cost including volume discounts (manufacturers' wholesale invoice). **Do not bill** your usual and customary fee.

- Supply items for hearing aids include tubing, wax guards, and ear hooks. These can be billed within the warranty period.
- Parts for hearing aids include switches, controls, filters, battery doors and volume control covers. These can be billed as replacement parts only, but not within the warranty period.
- Shells ("ear molds" in HCPCS codes) and other parts can be billed separately at acquisition cost. L&I **does not cover** disposable shells.

Hearing aid extra parts, options, circuits and switches, for example, T-coil and noise reduction switches, can only be billed when the manufacturer does not include these in the base invoice for the hearing aid.

All hearing aids, parts and supplies must be billed using HCPCS codes. Hearing aids and devices are considered to be durable medical equipment and must be billed at their acquisition cost.

Who may bill for hearing aid services and devices?

Audiologists, physicians, ARNPs and fitter/dispensers who have current L&I provider account numbers may bill for hearing aid replacement. You may bill for the acquisition cost of the non-linear aids and the associated professional fitting fee (dispensing fee).

What billing forms should providers use?

Fitters/dispensers and DME providers should use the department's **Statement for Miscellaneous Services Bill form** (F245-072-000).

Physicians, ARNPs, and licensed audiologists are to bill the department using the **CMS-1500 form** (F245-127-000).

For further information regarding hearing aid services, please refer to the "Professional Services" section of the current *Medical Aid Rules and Fee Schedule.*

Interpreter Services

Code/Description	Units of Service
9988M – Group Interpretation Direct services time between more than one client(s) and health care or vocational provider, includes wait and form completion time, time divided between all clients participating in group, per minute.	Bill 1 unit for each minute
9989M – Individual Interpretation Direct services time between insured and health care or vocational provider, includes wait and form completion time, per minute.	Bill 1 unit for each minute
9996M – IME No show Interpreter	Bill 1 unit only per occurrence
9986M – Mileage	Bill 1 unit for each mile
9997M – Document Translation	Bill 1 unit for each page translated

Interpretive Services providers must provide proof of their credentials using the "Submission of Credentials for Interpretive Providers" form F245-055-000. This form is available online as well as from Provider Accounts.

Interpretive Services Appointment Record form and mileage verification must be in the claim file at the same time you bill the insurer or your bill may not be paid.
Document translation services are only paid when performed at the request of L&I or the self-insurer. Services will be authorized before the request packet is sent to the translator.
Individual Interpretation Services: You must bill services for the same client, for the same date of service on one bill or your bill may not be paid.

Group Interpretation Services: Time and mileage is divided between all clients participating in group. Send a separate bill for each client with prorated amounts. Send Interpretive Services Appointment Record form and mileage verification to each workers' compensation client's file.

Adjustment vs. Submitting a New Bill for State Fund claims

- When the whole bill is denied, then you need to submit a new bill.
- When part of the bill is paid, then you do an adjustment. Additional information on adjustment is available at http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/PayAdjust/default.asp.

If the time or mileage needs to be corrected you should adjust the **last paid** bill.

Refer to the "Professional Services" section of the current *Medical Aid Rules and Fee Schedules* for further information regarding interpreter services including:

• L&I authorization and limit information • Interpreters/Translators not eligible for payment • Credential required for L&I provider account number • Covered and non-covered services	• Individual interpretation services billing information • Group interpretation services billing information • Mileage and travel billing information • Billing examples • Standards and responsibilities for interpretive services

Additional information is also available at the L&I Interpreter Services web site at:http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/default.asp

Do not staple Interpretive Services Appointment Record form and mileage verification to bill forms. Send or fax documentation separately from bills for State Fund or Crime Victims Compensation Program claims to:

State Fund

Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291
(360) 902-6500
1-800-848-0811
Or Fax number to 360-902-4567:

Crime Victims Compensation Program

Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520
(360) 902-5377
1-800-762-3716

Self-Insurer

Send self-insured **bills and reports** directly to the SIE/TPA.
For a list of SIE/TPAs and their contact information, go to:
http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp
.

Send State Fund Bills to:

Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

Licensed Massage Therapy

Note: DO NOT bill services spanning multiple dates of service. Bill one date per line.

Massage is a **covered** physical medicine service when performed by a licensed massage therapist (WAC 296-23-250) or other provider whose scope of practice includes massage techniques.

Massage therapists must bill CPT® code 97124 for all forms of massage therapy, regardless of the technique used. The insurer **will not pay** massage therapists for additional codes.

Massage therapists must bill their usual and customary fee and designate the duration of the massage therapy treatment.

Massage therapy is paid at 75% of the maximum daily rate for physical and occupational therapy services.

The daily maximum allowable amount is $ 88.55

The following are bundled into the massage therapy service and are not separately payable:

- Application of hot or cold packs,
- Anti-friction devices and
- Lubricants (For example, oils, lotions, emollients).

Document the amount of time spent performing the treatment. Your documentation must support the units of service billed.

Refer to WAC 296-23-250 for additional information.

Units Reported on the Claim	Number Minutes
1 unit	≥ 8 minutes to < 23 minutes
2 units	≥ 23 minutes to < 38 minutes
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥113 minutes to < 128 minutes

NOTE: The above schedule of times does not imply that any minute until the 8th should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

Report the duration of treatment for each timed code billed in the daily treatment note. You must submit all documents that support your billing (e.g. flow sheets and chart notes.)

More information about L&I's Massage Therapy policies is also available on L&I's web site at

http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/default.asp

Refer to WAC 296-20-030 & WAC 296-23 for additional information.

Authorization Required:

"Massage therapy treatment will be permitted when given by a licensed massage practitioner only upon written orders from the worker's attending doctor."

"Massage therapy treatment beyond the initial six treatments will be authorized only upon substantiation of improvement in the worker's condition in terms of functional modalities, i.e., range of motion; sitting and standing tolerance; reduction in medication, etc."

"Massage therapy in the home and/or places other than the practitioners usual and customary business facilities will be allowed only upon prior justification and authorization by the department or self-insurer."

"Massage therapy treatments exceeding once per day must be justified by attending doctor."

Please refer to WAC 296-23-250 for additional information and reporting requirements.

Lodging/Meal Services

0406A Lodging
0407A Breakfast
0408A Lunch
0409A Dinner
1061M Per Diem (Lodging/Meals)

Nurse Case Management

All nurse case management (NCM) services require prior authorization. Contact the insurer to make a referral for NCM services.
NCM services are capped at 50 hours of service, including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases, contingent upon review by the insurer.

Case Management Records and Reports

Case management records must be created and maintained on each claim. The record shall present a chronological history of the worker's progress in NCM services.
Case notes shall be written when a service is given and shall specify:

- When the service was provided and
- What type of service was provided using case note codes and
- Description of the service provided including subjective and objective data and
- How much time was used during this reporting period.

NCM reports shall be completed monthly. Payment will be restricted to up to 2 hours for initial reports and up to 1 hour for progress and closure reports.

Copies of reports, correspondence, and expenses shall be maintained in the case record.

Nurse case managers must use the following local codes to bill for NCM services, including nursing assessments:

Code	Description	Maximum Fee
1220M	Phone calls, per 6 minute unit	$ 9.64
1221M	Visits, per 6 minute unit	$ 9.64
1222M	Case planning, per 6 minute unit	$ 9.64
1223M	Travel/Wait, per 6 minute unit (16 hour limit)	$ 4.74
1224M	Mileage, per mile – greater than 600 miles requires prior authorization from the claim manager	State rate
1225M	Expenses (parking, ferry, toll fees, cab, lodging and airfare) at cost or state per diem rate (meals and lodging). Requires prior authorization from the claim manager ($725 limit)	By report

Billing Units Information

- Units are whole numbers and not tenths units
- Each traveled mile is 1 unit of service
- Each 6 minutes of care coordination or travel/wait time is 1 unit of service
- Each related travel expense is 1 unit of service

Minutes = # of Units	Minutes = # of Units
6 = 1	36 = 6
12 = 2	42 = 7
16 = 3	48 = 8
24 = 4	54 = 9
30 = 5	60 = 10

Case note codes shall be converted to billing codes as bills are processed by the nurse case manager or firm. For example, all time associated with telephone calls during a 30-day period is added, converted to units of service and then total charges. Likewise, all time associated with visits during a 30-day period is added, converted to units of service and then total charges, etc. Examples below describe how to convert time to units and calculate total charges. Examples are also shown for mileage and expenses.

Phone Calls, Visits or Case Planning:

Step 1 – Time to Units

Total minutes divided by 6 = Total No. of Units 102 minutes/6 = 17 units

Step 2 – Units of Total Charges

Total units time per unit charge = Total charges 17 units x $9.64 = $163.88

Travel / Wait:

Step 1 – Time to Units

Total minutes divided by 6 = Total No. of Units 150 minutes/6 = 25 units

Step 2 – Units to Total Charges

Total units times per unit charge = Total charges 25 units x $4.74 = $118.50

Mileage:

Mileage is reimbursed at the Washington State rate for mileage reimbursement. The current amount is available at http://www.ofm.wa.gov/policy/10.90.htm. The rate effective January 1, 2010 is $.50 per mile. Mileage during a 30-day period is added then multiplied by .50 to obtain the total mileage expenses for the month. For example:

112 miles x .50 = $56.00

Expenses:

Expenses will be reimbursed at cost. Receipts for expenses shall be maintained in the case record. Receipts for parking are not required, but preferred. All expenses with a 30-day period shall be added, and then coded as 1225M on the Statement for Miscellaneous Services bill form.

Attachment B describes covered and non-covered medical case management expenses.

An example follows:

$5.00 (parking) + $7.50 (records) = $12.50

For further information regarding nurse case management services, please refer to the "Professional Services" section of the current Medical Aid Rules and Fee Schedule.

CASE NOTE CODES

Phone Calls

- PCW: Injured worker, family members, injured workers' attorney or legal representative.
- PCD: Department of Labor and Industries staff.
- PCE: Employer or employer representatives.
- PCV: Vocational rehabilitation counselors.
- PCP: Attending physician, physician consultants, and other allied healthcare personnel.
- PCO: Governmental agencies, social services, community and/or volunteer resources, etc.

Visits

- VW: Injured worker, family members, injured workers' attorney or legal representative.
- VD: Department of Labor and Industries staff.
- VE: Employer or employer representative
- VP: Attending physician, physician consultants, and other allied healthcare personnel.
- VO: Governmental agencies, social services, community and/or volunteer resources, etc.

Case Planning

- CR: Case Review: review and analyze current or new data between monthly reporting periods.
- FRV: File Record Review: review and analyze historical file documentation.
- COR: Correspondence: prepare correspondence, i.e., letters memo, fax.
- RE: Research: research medical literature, condition specific.
- RW: Report Writing: prepare monthly reports, i.e., initial, progress and closure reports and special reports.
- RR: Record Retrieval: obtain medical records, reports or evaluations.
- TC: Team Conference: participate in or conduct team conferences.

Travel / Wait

- TR: Travel: travel to person being visited
- WA: Wait to meet with person(s) being visited.

Mileage **Not applicable**.

Expenses **Not applicable**.

CASE NOTE CODES, DESCRIPTIONS AND INSTRUCTIONS

PHONE CALLS

Definition: made by or to a nurse case manager for consultation, coordinating medical services or for case planning with the persons listed below. This service is to be used to clarify or alter previous instructions; to integrate new information from other health care professionals into the medical treatment plan; or to assess the need to modify or change the current treatment plan to facilitate the worker's recovery; to assess the success of current therapies or treatment, overall.

Billing Instructions: Bill 1 unit of service for each 6 minutes of time. Documentation of the service is to include a case note describing each instance when a service was performed and billed. The case notes will contain the date of the call, to whom the phone call was made, their title if applicable (MD, RN, DO, PT, etc.), the reason for the call, details of the discussion and length of phone call.

Billing codes and Descriptions:

PCW:	Includes phone calls to injured worker, family members, injured worker's attorney or legal representatives.
PCD:	Includes phone calls to Department of Labor and Industries claims managers, occupational nursing consultants, supervisors, and other department staff.
PCE:	Includes phone calls to employer or employer representatives to access information or facilitate return to work for the injured worker.
PCV:	Includes phone calls to vocational rehabilitation counselors for coordination of rehabilitation services.
PCP:	Includes calls to attending physician, physician consultants, and other allied health care personnel to facilitate health care service delivery.
PCO:	Includes phone calls to other governmental agencies, social services, community and/or volunteer resources to provide for the injured worker's health care needs.

VISITS

Definition: Onsite meetings or scheduled face-to-face meetings by a nurse case manager for consultation, coordinating medical services or for case planning with the persons listed below. This service is to be used to clarify or alter previous instruction; to integrate new information from other health care professionals into the medical treatment plan; or to assess the need to modify or change the current treatment plan to further recovery; to assess the success of current therapies or treatment overall when telephonic services are not adequate to obtain the necessary information.

Billing Instructions: Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include a case note describing each instance when a service was performed and billed. The case notes will contain the date of the visit, who was visited, their title if applicable (MD, RN, DO, PT, etc.), the reason for the visit, details discussed and the length of visit.

Codes and Descriptions:

VW:	Includes visits with injured worker, family members, injured workers' attorney or legal representative.
VD:	Includes visits with the Department of Labor and Industries claims managers, occupational nursing consultants, supervisors, and other department staff.
VE:	Includes visits to employer or employer representatives to access information or facilitate return to work for the injured worker.
VV:	Includes visits with vocational rehabilitation counselors for coordination of rehabilitation services.
VP:	Visits with the attending physician consultants, and other allied health care personnel to facilitate health care service delivery.
VO:	Visits with other governmental agencies, social services, community and/or volunteer resources to provide for the injured worker's health care needs.

CASE PLANNING

1) Case Review (CR)

Definition / Billing Instructions: The time taken to review and analyze current or new data between monthly reporting periods; includes documentation of impact of new data on overall case plan. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include the date, case note with the data and description of the data, analysis, and plan. Case planning is not to be billed for writing case notes to document onsite visits or phone calls. Phone calls and visits already include payment for associated documentation.

2) File Record Review (FRV)

Definition / Billing Instructions: The time taken to review and analyze historical file documentation at the onset of referral to medical case management. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include a case note describing the date of review, material reviewed, and time spent reviewing the records. If a separate file review is completed, a copy of the document will be kept in the working file and attached to the monthly report. Copies of historical file documents shall be kept with the nurse case manager's case record.

3) Correspondence (COR)

Definition / Billing Instructions: The time taken to prepare correspondence, i.e., letters, memo, fax to the department, injured worker, provider, vocational counselor and other governmental agencies, social services, community and/or volunteer resources for the purpose of updating, clarifying or confirming the medical treatment plan. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include the date when the correspondence was produced, a case note describing the correspondence and time to prepare the correspondence. A copy of the document will be kept in the case record and attached to the monthly report.

4) Research (RE)

Definition / Billing Instructions: The time taken to research medical literature, condition specific. Bill 1 unit of service for each 6 minutes of time.

Documentation of this service is to include the date research was conducted, a summary of the findings of the literature review, the impact of the information on the injured worker's case plan, and time to complete research. If document produced, a copy will be kept in the case record and attach to the monthly report.

5) Report Writing (RW)

Definition / Billing Instructions: The time taken to prepare monthly reports, i.e., initial, progress and closure reports, as well as special reports requested by department representatives. Bill 1 unit of service for each 6 minutes of time. The initial report shall not exceed 2 billable hours per case. Progress and closure reports shall not exceed 1 hour per case.

Documentation of this service is to include the date of the report, a notation in the case notes, a report, (for special reports, note requesting part in case note documentation using appropriate billing code, e.g., PCD or VD) and the time to complete the report. A copy of the report will be kept in the case record and sent to the claims representative on a monthly basis.

6) Record Retrieval (RR)

Definition / Billing Instructions: The time taken to obtain records, reports or evaluations not currently contained in the department's records for case planning. This method of obtaining records should be limited. The most cost-effective method of obtaining records should be used first, prior to use of professional time, e.g., faxing, mailing, etc. Bill 1 unit of service for each 6 minutes of time.

Documentation of this service is to include the date of record retrieval, a case note identifying the record source, summary of records obtained, and the total time (including travel, wait, and photocopying cost) to obtain the report.

7) Team Conference (TC)

Definition / Billing Instructions: The time taken to participate in or conduct a team conference with 3 or more health care professionals, vocational rehabilitation counselors, employer, injured worker and/or representative, or other governmental agencies, social services, community and/or volunteer resources to coordinate activities of patient care, provide for the injured worker's health care needs and/or return to work efforts for the injured worker. Includes documentation of impact of conference data on the overall case plan. Bill 1 unit of service for each 6 minutes of time. Visit codes are not to be billed for team conferences.

Documentation of this service is to include the date of the conference, a case note, summary of conference findings, analysis, plan of action, and time.

TRAVEL (TR)

Definition / Billing Instructions: The time to travel from the nurse case manager's home office or home, whichever is closest, to the person being visited. Bill 1 unit of service for each 6 minutes of time. Transportation costs including parking, ferry, toll fees, cab, and airfare are reimbursable at cost. Travel expenses resulting from single or multiple visits which involve visits or conferences on more than one injured worker must be prorated between the multiple injured workers visited. For example, if the case manager travels to a hospital in Seattle, and visits with 3 injured workers, the costs should be billed by dividing the mileage and travel time between the three cases.

Documentation of the service is to include date of travel, a case note with starting and ending location, whether visit was prorated, mileage, odometer reading start and finish, and other associated transportation expenses, and time.

Mileage costs may be reimbursed at the current Washington state rate for mileage reimbursement. Mileage costs should be billed using the 1224M mileage billing code. Parking, toll, ferry, cab or airfare expenses will be billed with the new 1225M expense billing code. Meals and lodging required outside normal business hours will be paid with prior approval by the claims manager and at the state per diem rate in effect at the time for the area. Meals and lodging and a copy of any original invoice shall be kept in the case record for a minimum of five years.

WAIT (WA)

Definition / Billing Instructions: The time to wait to meet with person(s) being visited during scheduled visits. Bill 1 unit of service for each 6 minutes of time to a maximum of 16 hours. Case managers are encouraged to use wait time to conduct other business e.g., phone calls, visits, case planning, file record review, and record retrieval during wait time.

Documentation of the service is to include the date of wait time, a case note with location of visit, time of arrival at appointment, and end time (when appointment visit began).

ATTACHMENT B

COVERED AND NON-COVERED EXPENSES

COVERED EXPENSES:

The following expenses will be covered –

- ❖ Transportation other than mileage, including parking, ferry, toll fees, and cab. Mileage is reimbursed at the current Washington state rate for mileage reimbursement.
- ❖ Meals and lodging required outside normal business hours with prior claims manager approval and at the Washington state per diem rate in effect at the time for the area.
- ❖ Airfare with prior approval from the claim manager.
- ❖ Mileage greater than 600 miles round trip requires prior approval from the claims manager.
- ❖ Fees for obtaining medical records, reports or evaluations per request of department and at no more than the maximum allowable rate of .48 per page. For further information regarding fees for obtaining medical records, reports or evaluations, please refer to the "Professional Services" section of the current *Medical Aid Rules and Fee Schedules*.

NON-COVERED EXPENSES:

The following expenses will not be covered –

- ❖ Activities associated with nurse case manager training, e.g., training on office policies and procedures, including report writing and billing.
- ❖ Supervisory activity such as supervisor – nurse case manager visits, case reviews or conferences between supervisor and nurse case manager.
- ❖ Postage, printing or photocopying costs (with the exception of medical records per request of department). See above explanation.
- ❖ Telephone expenses including unanswered phone calls, long-distance phone calls, and facsimile.
- ❖ Time spent on any clerical activity, including processing a referral, file "set up", typing, copying, mailing, distributing, filing, invoice preparation, record keeping, delivering or picking up mail.
- ❖ Travel time to a post office or a fax machine.
- ❖ Wait time exceeding 16 hours.
- ❖ Fees related to legal work, e.g., deposition, testimony, etc. Legal fees may be charged to the requesting party, but not the claim. Contact the requesting party regarding how legal services are billed.
- ❖ Any other administrative cost not specifically mentioned above.

Obesity Treatment

Obesity does not meet the definition of an industrial injury or occupational disease.
Temporary treatment may be allowed when the unrelated obesity condition hinders recovery from an accepted condition.

Prior authorization is required for all obesity treatment services.

To be eligible for obesity treatment, the worker must be severely obese. Severe obesity for the purposes of providing obesity treatment is defined by L&I as a Body Mass Index (BMI) of 35 or greater.

The worker pays the joining fee and weekly membership fees up front for programs and can be reimbursed. The worker is eligible for dietician services with a doctor's order and prior auth of the CM. Only certified dieticians (CDs) can be paid for counseling services.

The procedure codes for dietician counseling are as follows:

97802 Initial visit, maximum of 4 units
97803 Maximum 2 units per visit with maximum of 3 visits

For further information regarding obesity treatment services, please refer to the "Professional Services" section of the current Medical Aid Rules and Fee Schedule.

Occupational Therapy (Vocational Services)

Code	Description	Maximum Fee
0378R	Stand Alone Job Analysis – (non-VRC) 1 unit = 6 minutes	$8.77
0389R	Pre-job or Job Modification Consultation, 1 unit = 6 minutes	$ 10.66
0390R	Vocational Evaluation, 1 unit = 6 minutes	$ 8.77
0391R	Travel/Wait (non-VRC), 1 unit = 6 minutes	$ 4.83
0392R	Mileage (non-VRC), one unit = 1 mile	State rate
0393R	Ferry Charges (non-VRC)(1)	State rate

(1) Requires documentation with a receipt in the case file.

Occupational Therapy

Occupational therapy services must be provided by a licensed occupational therapist or occupational therapy assistant serving under the direction of a licensed occupational therapist (see WAC 296-23-230).

Physical and occupational therapists must use the appropriate CPT® and HCPCS codes 64550, 95831-95852, 95992, 97001-97799 and G0283, with the exceptions noted later in the Non-covered and Bundled Codes section. They must bill the appropriate **covered** HCPCS codes for miscellaneous materials and supplies. For information on surgical dressings dispensed for home use, refer to the Supplies, Materials and Bundled Services section. If more than 1 patient is treated at the same time use CPT® code 97150. Refer to the Physical Medicine CPT® Codes Billing Guidance section for additional information.

Use CPT® codes 97001 through 97004 to bill for physical and occupational therapy evaluations and reevaluations. Use CPT® codes 97001 and 97003 to report the evaluation by the physician or therapist to establish a plan of care. Use CPT® codes 97002 and 97004 to report the evaluation of a patient who has been under a plan of care established by the physician or therapist in order to revise the plan of care. CPT® codes 97002 and 97004 have no limit on how frequently they can be billed.

PHYSICAL CAPACITIES EVALUATION

The following local code is payable only to physicians who are board qualified or certified in physical medicine and rehabilitation, and physical and occupational therapists. The evaluation must be provided as a 1-on-1 service.

1045M Performance-based physical capacities evaluation with report and summary of capacities….$705.78 (Limit of 1 per 30 days per claim)

See WAC 296-23-230 for additional information regarding Occupational Therapy Rules.

For further information regarding occupational therapy services, please refer to the "Professional Services" section of the current *Medical Aid Rules and Fee Schedule*.

Optometry/Optician Services

Please refer to WAC 296-20-100 Eyeglasses and refractions for more information.

Physical Therapy (Vocational Services)

Code	Description	Maximum Fee
0378R	Stand Alone Job Analysis (non-VOC)	$8.77
0389R	Pre-job or Job Modification Consultation, 1 unit = 6 minutes	$ 10.66
0390R	Vocational Evaluation, 1 unit = 6 minutes	$ 8.77
0391R	Travel/Wait (non-VRC), 1 unit = 6 minutes	$ 4.83
0392R	Mileage (non-VRC), one unit = 1 mile	State rate
0393R	Ferry Charges (non-VRC)[1]	State rate

(1) Requires documentation with a receipt in the case file.

Vocational Rehabilitation Services

This section details the requirements and information Vocational Rehabilitation providers should know and follow in submitting bills.

How to Submit a Bill

Each provider who works on a referral must bill separately and must list the precise number of units of service worked for each date span on a referral. Each date span billed must have both a start and end date. The provider must also bill for each referral separately. Even if a third party does the billing, the provider receiving the referral is responsible for ensuring that all billing is correct.

Multiple providers may deliver services on a single referral if they have the **same** payee provider account number. This situation might occur when interns assist on referrals assigned to VRCs, or where 1 provider covers the caseload of an ill provider. When more than 1 provider works on a referral, each provider must bill separately for services delivered on the referral; and each provider must use:

His/her individual provider account number,

The payee provider account number and

The referral ID.

If several providers work on a single referral, the assigned provider is ultimately responsible for the referral. The performance data associated with that referral accrues to the **assigned** provider's performance rating.

Example: Acme Rehabilitation employs counselor X, as well as interns Y and Z. Acme may not submit aggregate bills: Acme Rehabilitation must submit a separate bill for Counselor X, Intern Y, and Intern Z—for each referral worked by X, Y, and Z.

For more detailed information about completing billing forms, consult the samples of completed forms, which are located in an attached section.

Reimbursement Rates

Each referral is a separate authorization for services. L&I will pay interns at 85% of the Vocational Rehabilitation Counselor (VRC) professional rate and forensic evaluators at 120% of the VRC professional rate.

The table below lists the professional, travel/wait, and mileage rates for vocational services:

Provider Type	Rate
VRC Professional Rate	$87.70/hour
Intern Professional Rate	$74.70/hour
Forensic Rate	$105.00/hour
Travel/wait Rate	$43.80/hour
Mileage Rate	Current State Rate/mile

Fee Caps and Thresholds

As part of the changes to the reimbursement structure, the department has adopted fee caps. Providers must be aware that fee caps are ***hard*** caps, with ***no*** exceptions.

When cumulative payments for a referral have reached the cap, the Remittance Advice sent with the State Fund bill payment will contain an Explanation of Benefits, indicating that the referral has reached its fee cap. The department will adjust the amount of the bill to pay no more than the fee cap allows and will authorize no payment beyond the cap. It is very important that vocational providers work closely with their billing staffs to monitor costs on their referrals.

At 100 percent of the fee cap, the claim manager is notified and instructed to close the referral. When the claims manager has closed the referral, the vocational provider must submit a closing report.

Please consult the following fee cap table:

Description	Applicable Codes	Maximum Fee
Early Intervention Referral Cap, per referral	0800V, 0801V	$1,801.00
Extension of Early Intervention Referral Cap, once per claim	0802V, 0803V	$ 1,756.00
Assessment Referral Cap, per referral	0810V, 0811V	$3,003.00
Assessment Services Exception (vrc), (Intern) additional fee cap	0812V,0813V	$877.00
Plan Development Referral Cap, per referral	0830V, 0831V	$6,014.00
Plan Implementation Referral Cap, per referral	0840V, 0841V	$6,818.00
Plan Implementation Services Exception (VRC),(Intern) additional fee cap	0842V,0843V	$2026.00
Stand Alone Job Analysis Referral Cap, per referral	0808V, 0809V, 0378R	$ 459.00

The fee cap for vocational evaluation services applies to multiple referral types.

Description	Applicable Codes	Maximum Fee
Work Evaluation Services Cap	0821V, 0390R	$1,316.00

Code	Fee Cap	Comments

Codes

The following table lists the codes, and their corresponding definitions, for use in billing for vocational services. Reimbursement will occur according to the level of provider described below. Separate codes and provider specialties exist for vocational interns, counselors, and forensic specialists.

Example: Intern Y at Acme Rehabilitation bills code 0881V. Result: The department does not pay, because it only authorizes qualified providers to do forensic work.

Code	Description	Counselor Level
	EARLY INTERVENTION	
0800V	Early Intervention Services	VRC
0801V	Early Intervention Services—Intern	Intern
0802V	Graduated RTW and Work Hardening	
0803V	Graduated RTW and Work Hardening	Intern
	STAND ALONE JOB ANALYSIS	
0808V	Stand Alone or Provisional Job Analysis	VRC
0809V	Stand Alone or Provisional Job Analysis – Intern	Intern
	ASSESSMENT	
0810V	Assessment Services	VRC
0811V	Assessment Services—Intern	Intern
	VOCATIONAL EVALUATION	
0821V	Work Evaluation	VRC
0823V	Pre-job or Job Modification Consultation	VRC
0824V	Pre-job or Job Modification Consultation—Intern	Intern
	PLAN DEVELOPMENT	
0830V	Plan Development Services	VRC
0831V	Plan Development Services—Intern	Intern
	PLAN IMPLEMENTATION	
0840V	Plan Implementation Services	VRC
0841V	Plan Implementation Services—Intern	Intern
	FORENSIC AND TESTIMONY	
0881V	Forensic Services	VRC—Forensic
0882V	Testimony on VRC's Own Work	VRC
0883V	Testimony on Intern's Own Work	Intern
0884V	AGO Witness Testimony	VRC

	OTHER	
0891V	Travel/Wait Time	VRC
0892V	Travel/Wait Time—Intern	Intern
0893V	Professional Mileage	VRC
0894V	Professional Mileage—Intern	Intern
0895V	Air Travel	Intern/VRC/ VRC—Forensic

Codes

The codes are:

Code & Description	Early Int.	Assess.	Plan Dev.	Plan Imp.	Forensic	Provider Type(s)
0896V – Ferry Charges	M	M	M	M	M	68
0897V – Hotel Charges *	O	O	O	O	O	68
0391R – Travel/wait (non–voc)	O	O	O	O	O	34, 52, 55, 97
0392R – Mileage (non-voc)	O	O	O	O	O	34, 52, 55, 97
0393R – Ferry Charges (non-voc)	O	O	O	O	O	34, 52, 55, 97

* This code is only allowable for approved out of state cases.
M – code loads automatically when referral is made
O – claim manager must load code after specific authorization

Ancillary Services
As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider number than you), you cannot bill as a vocational provider (a provider type 68). You must use another provider number that is authorized to bill the ancillary services codes (type 34, 52, 55) or obtain a miscellaneous service provider number (type 97) and bill the appropriate codes for those services.

Codes 0896V, 0897V, and 0393R are payable By Report, and a receipt must be placed in the case file for documentation. Code 0391R pays at $4.83 per unit. Recall that the department requires billing for services in units, in increments of 6 minutes per unit, or 10 units per hour. Code 0392R pays at the standard federal rate per mile, similar to codes 0893V and 0894V.

Stand Alone or Provisional Job Analysis
This type of request authorizes a vocational provider to conduct a job analysis when no other services are needed. The claim may be allowed or in provisional status. The assigned vocational provider is responsible for all work performed by all providers in the completion of that referral. A physical or occupational therapist may perform work and should follow the instructions under their section of these instructions. The combined fees of all the providers will accrue to a single fee cap.

Date Span Information

When providers are completing billing forms, it is very important to include both start and end dates for the date span of services. Providers must include all services provided during this date span on the bill. They may not submit a new bill for additional services during the same date span. If this circumstance occurs on a State Fund bill, a "Provider's Request for Adjustment" form must be completed to adjust the original charges.

Units of Service

One unit of service equals 6 minutes of time. The stated hourly rate is equal to 10 units of service. The unit of service for mileage reimbursement is per one mile. This applies to all 'V' (Voc) procedure code and 'R' procedure codes as applicable.

Example: the professional VRC rate is $87.70 per hour; 1unit of service (6 minutes) pays $8.77 ($87.70/10); 2 units of service (12 minutes) pays 2 x $8.77 = $17.54

Referral Identification Number on Bills

When completing billing forms, a provider must include the referral identification numbers for each submitted bill. The department will deny payment for any bill submitted without a referral identification number. Each department referral has a unique referral identification number.

Documentation

Documentation that supports billing includes the provider's case notes. Providers should ensure that their case notes include evidence of the time spent on various activities. **Example:** A provider who spends a half-hour on a progress report for a case might specify that half-hour in his or her case notes as ".5 hours preparing progress report." Specific requirements for case note documentation can be found in the rules governing vocational rehabilitation services, WAC 296-19 Chapter A.

Travel/Wait and Mileage

The department developed separate codes for vocational providers' travel/wait time. The department pays for work performed by providers on vocational referrals only from the branch office where the referral was assigned. The department does NOT pay for travel time between two different service locations or branch offices where a provider is working cases.

Providers should bill from the branch office where the referral has been received by the VRC to necessary destinations, such as the following: going to the location of the employer of record, visiting an attending physician's office, and the meeting of a VRC with an injured worker at his or her home. For out of state cases, VRC may only bill from the branch office nearest the worker.

Vocational provider case notes must specify point of origin for travel. Travel is normally billed from assigned service location, but when travel is actually less, it should be billed as less. For example, if referral is made to Olympia service location and the vocational provider travels from Tacoma branch to Seattle training site; it should be billed for the lesser distance.

Example: A vocational counselor indicates to the department that he or she is willing to work referrals in Seattle, Yakima, and Longview.

Result: The department will reimburse the provider for travel/wait time on cases in each of these three areas, but will not pay for the provider to drive from Seattle to Yakima, or from Longview to work a Seattle or Yakima referral.

Travel/wait is reimbursed at 50% of the standard vocational counselor rate, regardless of referral type or provider specialty. Travel/wait must be pro-rated if more than one referral is included in a particular trip.

Mileage, as determined by the federal rate, is reimbursed at the same rate as that of travel on state business. The department reimburses mileage at the same rate, regardless of referral type or provider specialty.

Obtaining a Copy of the Vocational Rehabilitation Rules

Providers can obtain a copy of the rules governing vocational services (WAC 296-19A) through the Internet at the following address: http://www.leg.wa.gov/LawsAndAgencyRules/

COMPLETING THE “STATEMENT FOR MISCELLANEOUS SERVICES” FORM

The Department of Labor and Industries and service providers are joined in a cooperative process for payment of provider billings. In order to process the billings in a timely manner, the billings must be completed as described. Improperly completed bill forms may be returned to the provider for completion/correction and resubmission.

Completed bill forms MUST be typed or printed and be clearly legible. Bills must be submitted on ORIGINAL (not photocopies or facsimiles) Statement for Miscellaneous Services forms. All boxes on the form other than those identified, as “not applicable” MUST be completed to ensure correct bill adjudication.

DO NOT STAPLE ANY ATTACHMENTS IN THE BAR CODE AREA AT THE TOP OF THE FORM.

All boxes on the form other than those identified, as “not applicable” **must** be completed in order to ensure correct bill adjudication.

1. Check the box indicating the applicable category of service. If your particular service category is not listed, check the “OTHER” box (e.g., interpreter services and licensed massage therapists would check the “other” box).

2. **WORKER’S NAME:** Enter worker’s last name, first name and middle name or initial.

3. **SOCIAL SECURITY NUMBER:** Enter worker’s social security number. This information will assist us in identifying the injured worker’s claim number if the claim number is missing or invalid.

4. **CLAIM NUMBER:** Enter the department-assigned claim number for the injury/condition being treated. Omission of this number will result in denial of payment.

   Claim numbers are alpha-numeric, consisting of seven characters. The letter identifies the funding source, which is listed below.

   STATE FUND INDUSTRIAL INSURANCE
   All State Fund claim numbers contain six digits and are preceded by one of the following letters: B, C, F, G, H, J, K, L, M, N, P, X, Y or double alpha followed by 5 digits.

   Send bills for State Fund claims to:

   Department of Labor and Industries
   PO Box 44269
   Olympia WA 98504-4269

   CRIME VICTIM COMPENSATION PROGRAM
   Crime victim claim numbers are either six digits preceded by a “V”, or five digits preceded by a VA-VZ.

   Send Bills for Crime Victims claims to:

   Department of Labor and Industries
   Crime Victims Compensation Program
   PO Box 44520
   Olympia WA 98504-4520

SELF-INSURANCE
Self-Insurance claim numbers are six digits preceded by an “S, T, W or double alpha (SA-SZ, TA-TZ, WA-WZ).” Self-Insurance claims should be sent directly to the employer or their service company. Department bill forms, Self-Insured forms, or other forms acceptable to the Self-Insurer may be used. If you have any questions about Self-Insured billing, please call the worker’s employer or Labor and Industries’ Self-Insurance section at (360) 902-6901.

5. **ADDRESS:** Enter worker’s current address.

6. **EMPLOYER'S NAME:** Enter worker’s employer’s name.

* **REIMBURSE INJ WORKER:** Check applicable box indicating whether the worker has paid for the services.

7. **DATE OF INJURY/ILLNESS:** The date of injury/illness positively identifies each claim. This is important and **must** be included. A worker may have several claims; therefore, it is vital that the proper claim be identified and charged for services provided.

8. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:** Enter name of the doctor referring claimant to you, if applicable.

9. **REFERRING PHYSICIAN PROVIDER NUMBER/NPI:** Enter L&I provider account number and NPI of referring doctor.

10. **DIAGNOSIS:** ICD9-CM code is required except for vocational services, personal transportation, public transportation, ambulance, placement agency, interpreter, miscellaneous non-physician, lodging, vehicle modification and home modification providers. <u>**Designate left or right side of body, when applicable.**</u>

11. **FOR GLASSES:** Indicate “yes” or “no,” if applicable to service being provided.

12. **SERVICES RELATED TO HOSPITALIZATION:** Not applicable.

13. **ITEMIZATION OF SERVICES AND CHARGES:**
    A. **DATE OF SERVICE:** Record one date of service per line.

    B. **PLACE OF SERVICE:** Enter required 2-digit place of service code. See list of codes in the *Place of Service* section of this booklet or on the reverse side of the bill form.

    C. **PROCEDURE CODE:** This code identifies the procedures performed or items provided (CPT/HCPCS/Local Code). The department's ***Medical Aid Rules and Fee Schedules*** lists the procedure code. Enter <u>only one code per line.</u>

    D. **PROCEDURE CODE MODIFIER:** Use only if applicable to your provider type and service provided. Modifiers are listed in the RBRVS section of the current fee schedule.

    E. **DESCRIBE PROCEDURES:** Enter brief description of services or supplies furnished.

    F. **DENTAL TOOTH NUMBER:** Enter tooth number. (Dental Services use only)

    G. **HOME NURSING:** Enter number of hours. (Home Nursing Services use only)

H. **GLASSES:** Complete this box as indicated. (Optometrist & Optician use only)

I. **CHARGES:** Total line item charge. (Do not bill negative charges.)
J. **UNIT:** Enter the total number of days, units, total hours, or miles for the services billed on a line: e.g., rental, lodging, multiple packages of supplies, transportation, etc.

14. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** Enter the name of the provider providing the services (enter last name first) and current address. If there are any changes in the provider's address or status, immediately notify Provider Accounts in writing or via fax at the following address/fax number:

    Provider Accounts
    Department of Labor and Industries
    PO Box 44261
    Olympia WA 98504-4261
    Fax 360-902-4484

    PLEASE INCLUDE THE L&I PROVIDER ACCOUNT NUMBER(S) THAT YOU'RE SUBMITTING A CHANGE FOR ON YOUR CORRESPONDENCE.
    Indicating a new address on the bill will not change the department's record of your address and could delay payment.

15. **PROVIDER NUMBER:** Enter the L&I provider account number assigned by the department for the provider of service.

16. **NPI:** Enter the national provider identifier of the **provider of service, not the organization**.

17. **TOTAL CHARGE:** Total of **all** charges for services provided.

18. **YOUR PATIENT'S ACCOUNT NUMBER:** The number you use to identify your patient's account. This number is for your convenience only.

19. **BILL DATE:** The date your billing was prepared.

20. **REMARKS:** Enter any further information necessary to explain your charges.

21. **REFERRAL ID:** Enter appropriate referral identification number.

STATEMENT FOR MISCELLANEOUS SERVICES

DO NOT WRITE IN SPACE >

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☐ Other
- ☐ Home Health/ Nursing Home Services

WORKER'S NAME IN FULL First Middle Last	SSN (ID only)	Claim Number
Address	Employer's Name	
City State ZIP	Reimburse injured worker ☐ Yes ☐ No	If yes, receipt required

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.	For glasses, advise if old Rx was Available?	REFUND CERTIFICATION
1. 2. 3. 4. 5.	☐ Yes ☐ No Give hospitalization dates for inpatient Services Admitted _______/_______/_______ Discharged _______/_______/_______	I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof. CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	P O S	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
						No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Bill date: / /

Remarks:

Provider or Supplier name	Provider number	NPI	Taxonomy
Address			Total Charge
Total Charge			Phone Number
City State ZIP + 4			Your Patient's Account Number
Federal tax ID ☐ EIN ☐ SSN			
			Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☐ Other
- ☒ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE > SAMPLE ARNP

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

WORKER'S NAME IN FULL			Social Security Number (for ID only)	Claim Number
Last: Doe	First: John	Middle: A	123-45-6789	AA00000

Address	Employer's Name
123 E 5th Ave	ABC Employer

City	State	ZIP	Reimburse Injured Worker	
Any City	WA	98512	☐ Yes ☒ No	If yes, receipt required

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	XXXXX XXXXXXXX MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _______/_______/_______

Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	xxxxx		Description of service						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature

Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Provider's Name ARNP	0000000	0000000000	$ XX.XX

Address	Phone Number
123 E 5th Ave	(XXX) XXX-XXXX

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXXXX

Federal tax ID number	
XX-XXXXXXX	☒ EIN ☐ SSN

Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

☐ Dental Services
☐ Medical Equipment/ Prosthetics-Orthotics
☐ Transportation
☐ Home Health/ Nursing Home Services
☐ Glasses
☐ Vocational/ Retraining
☒ Other

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

DO NOT WRITE IN SPACE > SAMPLE CRNA

WORKER'S NAME IN FULL	Social Security Number (for ID only)	Claim Number
Last Doe First John Middle A	123-45-6789	AA00000
Address: 123 E 5th Ave	Employer's Name: ABC Employer	
City: Any City State: WA ZIP: 98512	Reimburse Injured Worker ☐ Yes ☒ No	If yes, receipt required

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	XXXXX XXXXXXXX MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _______/_______/_______

Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	xxxxx		Description of service						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature

Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Provider's Name CRNA	0000000	0000000000	$ XX.XX
Address: 123 E 5th Ave			Phone Number: (XXX) XXX-XXXX
City: Any City State ZIP + 4: WA 00000-0000			Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number: XX-XXXXXXX ☒ EIN ☐ SSN			
			Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

DO NOT WRITE IN SPACE > SAMPLE RNFA

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

- [ ] Dental Services
- [ ] Medical Equipment/ Prosthetics-Orthotics
- [ ] Transportation
- [x] Home Health/ Nursing Home Services
- [ ] Glasses
- [ ] Vocational/ Retraining
- [ ] Other

WORKER'S NAME IN FULL			Social Security Number (for ID only)	Claim Number
Last Doe	First John	Middle A	123-45-6789	AA 00000
Address: 123 E 5th Ave			Employer's Name: ABC Employer	
City: Any City	State: WA	ZIP: 98512	Reimburse Injured Worker ☐ Yes ☒ No	If yes, receipt required
Date of Injury: MM-DD-YY	Name of referring physician or other source: XXXXX XXXXXXXX MD		Referring physician provider number / NPI: 0000000 / 0000000000	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _______/_______/_______
Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	xxxxx		Description of service						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature   Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Provider's Name RNFA	0000000	0000000000	$ XX.XX
Address: 123 E 5th Ave			Phone Number: (XXX) XXX-XXXX
City: Any City	State: WA	ZIP + 4: 00000-0000	Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number: XX-XXXXXXX	☒ EIN ☐ SSN		
			Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

- [x] Dental Services
- [ ] Glasses
- [ ] Medical Equipment/ Prosthetics-Orthotics
- [ ] Vocational/ Retraining
- [ ] Transportation
- [ ] Other
- [ ] Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE > SAMPLE DENTAL

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

WORKER'S NAME IN FULL Last / First / Middle	Social Security Number (for ID only)	Claim Number
Doe John A	123-45-6789	AA 00000

Address	Employer's Name
123 E 5th Ave	ABC Employer

City	State	ZIP	Reimburse Injured Worker	If yes, receipt required
Any City	WA	98512	[ ] Yes [x] No	

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	XXXXX XXXXXXXX MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? [ ] Yes [ ] No

Give hospitalization dates for inpatient Services
Admitted _______/_______/_______
Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	D0120		Limited Oral Evaluation						$XX.XX	X	01/01/11
01/01/11	xx	D0330		Panoramic Film						$XX.XX	X	01/01/11
01/01/11	xx	D7111		Tooth Extraction	9					$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature
Bill date: MM / DD / YY
Remarks:

Provider or Supplier name	Provider number'	NPI	Total Charge
Provider's Name DDS	0000000	0000000000	$ XX.XX

Address	Phone Number
123 E 5th Ave	(XXX) XXX-XXXX

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXXXX

Federal tax ID number: XX-XXXXXXX [x] EIN [ ] SSN

Referral ID

DO NOT WRITE IN SPACE > SAMPLE DME

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

STATEMENT FOR MISCELLANEOUS SERVICES

- ☐ Dental Services
- ☒ Medical Equipment/ Prosthetics-Orthotics
- ☐ Transportation
- ☐ Home Health/ Nursing Home
- ☐ Glasses
- ☐ Vocational/ Retraining
- ☐ Other

WORKER'S NAME IN FULL			Social Security Number (for ID only)	Claim Number
Last: Doe	First: John	Middle: A	123-45-6789	AA 00000

Address: 123 E 5th Ave
Employer's Name: ABC Employer

City: Any City — State: WA — ZIP: 98512
Reimburse Injured Worker ☐ Yes ☒ No — If yes, receipt required

Date of Injury: MM-DD-YY
Name of referring physician or other source: XXXXX XXXXXXXX MD
Referring physician provider number / NPI: 0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _______/_______/_______
Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	K0001	RR	Standard Wheelchair - rental						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature — Bill date: MM / DD / YY

Remarks:

Provider or Supplier name: Provider's Name DME
Provider number: 0000000
NPI: 0000000000
Total Charge: $ XX.XX
Address: 123 E 5th Ave
Phone Number: (XXX) XXX-XXXX
City: Any City — State: WA — ZIP + 4: 00000-0000
Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number: XX-XXXXXXX ☒ EIN ☐ SSN
Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

DO NOT WRITE IN SPACE > **SAMPLE INTERPRETER DOCUMENT TRANSLATION**

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☒ Other
- ☐ Home Health/ Nursing Home Services

WORKER'S NAME IN FULL			Social Security Number (for ID only)	Claim Number
Last: Doe	First: John	Middle: A	123-45-6789	AA 00000

Address: 123 E 5th Ave
Employer's Name: ABC Employer
City: Any City State: WA ZIP: 98512
Reimburse Injured Worker: ☐ Yes ☒ No — If yes, receipt required
Date of Injury: MM-DD-YY
Name of referring physician or other source: John Smith MD
Referring physician provider number / NPI: 0000000/ 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _______/_______/_______
Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	9997M		Document Translation (bill 1 unit per page)						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature
Bill date: MM / DD / YY
Remarks:

Provider or Supplier name: Interpreter's Name
Provider number: 0000000
NPI: 0000000000
Total Charge: $ XX.XX
Address: Interpreter's Address
Phone Number: (555) 555-5555
City: Any City State: WA ZIP + 4: 00000-0000
Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number: XX-XXXXXXX ☒ EIN ☐ SSN
Referral ID

SAMPLE INTERPRETER BILLING FOR 1 CLIENT SERVED AT 2 APPOINTMENTS IN 1 DAY

DO NOT WRITE IN SPACE >

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

STATEMENT FOR MISCELLANEOUS SERVICES

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☒ Other
- ☐ Home Health/ Nursing Home Services

WORKER'S NAME IN FULL	Social Security Number (for ID only)	Claim Number
Last: Doe — First: John — Middle: A	123-45-6789	AA 00000

Address	Employer's Name
123 E 5th Ave	ABC Employer

City	State	ZIP	Reimburse Injured Worker	If yes, receipt required
Any City	WA	98512	☐ Yes ☒ No	

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	John Smith MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted ______/______/______
Discharged ______/______/______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	9989M		Individual Interpretation						$XX.XX	X	01/01/11
01/01/11	xx	9986M		Mileage						$XX.XX	X	01/01/11
01/01/11	xx	9989M		Individual Interpretation						$XX.XX	X	01/01/11
01/01/11	xx	9986M		Mileage						$XX.XX	X	01/01/11

CHARGES: Charge your usual and customary fees

UNITS:
Individual Interpretation: Unit = Number of minutes
Mileage: Unit = Number of miles

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature — Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Interpreter's Name	0000000	0000000000	$ XX.XX

Address	Phone Number
Interpreter's Address	(XXX) XXX-XXXX

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXXXX

Federal tax ID number	Referral ID
XX-XXXXXXX ☒ EIN ☐ SSN	

STATEMENT FOR MISCELLANEOUS SERVICES

- [ ] Dental Services
- [ ] Medical Equipment/ Prosthetics-Orthotics
- [ ] Transportation
- [ ] Home Health/ Nursing Home Services
- [ ] Glasses
- [ ] Vocational/ Retraining
- [x] Other

DO NOT WRITE IN SPACE > SAMPLE IME NO SHOW

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

WORKER'S NAME IN FULL	Social Security Number (for ID only)	Claim Number
Last: Doe / First: John / Middle: A	123-45-6789	AA 00000

Address	Employer's Name
123 E 5th Ave	ABC Employer

City	State	ZIP	Reimburse Injured Worker	If yes, receipt required
Any City	WA	98512	[ ] Yes [x] No	

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	John Smith MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? [ ] Yes [ ] No

Give hospitalization dates for inpatient Services

Admitted _______/_______/_______

Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	9996M		IME No Show (bill 1 unit only)						$XX.XX	X	01/01/11
01/01/11	xx	9986M		Mileage (bill 1 unit per mile)						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature   Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Interpreter's Name	0000000	0000000000	$ XX.XX

Address	Phone Number
Provider's Address	(XXX) XXX-XXXX

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXXXX

Federal tax ID number: XX-XXXXXXX [x] EIN [ ] SSN

Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

DO NOT WRITE IN SPACE >

SAMPLE INTERPRETER GROUP SERVICES CLIENT 1

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

☐ Dental Services
☐ Medical Equipment/ Prosthetics-Orthotics
☐ Transportation
☐ Home Health/ Nursing Home Services
☐ Glasses
☐ Vocational/ Retraining
☒ Other

WORKER'S NAME IN FULL Last / First / Middle	Social Security Number (for ID only)	Claim Number
Doe / John / A	123-45-6789	AA 00000

Address	Employer's Name
123 E 5th Ave	ABC Employer

City	State	ZIP	Reimburse Injured Worker	If yes, receipt required
Any City	WA	98512	☐ Yes ☒ No	

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	John Smith MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _______/_______/_______
Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	9988M		Group Interpretation (bill 1 unit per minute)						$XX.XX	X	01/01/11
01/01/11	xX	9986M		Mileage (bill 1 unit per mile)						$XX.XX	X	01/01/11
				DIVIDE TOTAL MINUTES & MILES BY # OF CLIENTS IN GROUP								
				SUBMIT SEPARATE BILL AND INTERPRETIVE SERVICES APPOINTMENT RECORD AND MILEAGE VERIFICATION FOR EACH L&I CLIENT.								

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature
Bill date: MM / DD / YY
Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Interpreter's Name	0000000	0000000000	$ XX.XX

Address	Phone Number
Provider's Address	(XXX) XXX-XXXX

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXXXX

Federal tax ID number: XX-XXXXXXX ☒ EIN ☐ SSN

Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

- [ ] Dental Services
- [ ] Glasses
- [ ] Medical Equipment/ Prosthetics-Orthotics
- [ ] Vocational/ Retraining
- [ ] Transportation
- [x] Other
- [ ] Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE INTERPRETER GROUP SERVICES CLIENT 2

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

WORKER'S NAME IN FULL			Social Security Number (for ID only)	Claim Number
Last: Smith	First: Sue	Middle: D	222-22-2222	AB 00000

Address	Employer's Name
302 Main Street	ABC Employer

City	State	ZIP	Reimburse Injured Worker	If yes, receipt required
Any City	WA	98512	☐ Yes ☒ No	

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	John Smith MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _______/_______/_______

Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	XX	9988M		Group Interpretation (bill 1 unit per minute)						$XX.XX	X	01/01/11
01/01/11	XX	9986M		Mileage (bill 1 unit per mile)						$XX.XX	X	01/01/11
				DIVIDE TOTAL MINUTES & MILES BY # OF CLIENTS IN GROUP								
				SUBMIT SEPARATE BILL AND INTERPRETIVE SERVICES APPOINTMENT RECORD AND MILEAGE VERIFICATION FOR EACH L&I CLIENT.								

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature

Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Interpreter's Name	0000000	0000000000	$ XX.XX

Address	Phone Number
Provider's Address	(XXX) XXX-XXXX

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXXXX

Federal tax ID number: XX-XXXXXXX ☒ EIN ☐ SSN

Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

- ☐ Dental Services
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Transportation
- ☐ Home Health/ Nursing Home Services
- ☐ Glasses
- ☐ Vocational/ Retraining
- ☒ Other

DO NOT WRITE IN SPACE >

SAMPLE LMT

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

WORKER'S NAME IN FULL			Social Security Number (for ID only)	Claim Number
Last Doe	First John	Middle A	123-45-6789	AA 00000

Address	Employer's Name
123 E 5th Ave	ABC Employer

City	State	ZIP	Reimburse Injured Worker	
Any City	WA	98512	☐ Yes ☒ No	If yes, receipt required

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	XXXXX XXXXXXXX MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _______/_______/_______

Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	P O S	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	97124		Massage						$XX.XX	X	01/01/11
01/08/11	X x	97124		Massage						$XX.XX	X	01/08/11
01/15/11	xx	97124		Massage						$XX.XX	X	01/15/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature

Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Provider's Name LMT	0000000	0000000000	$ XX.XX

Address	Phone Number
123 E 5th Ave	(XXX) XXX-XXXX

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXXXX

Federal tax ID number	
XX-XXXXXXX ☒ EIN ☐ SSN	Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

- [ ] Dental Services
- [ ] Glasses
- [ ] Medical Equipment/ Prosthetics-Orthotics
- [ ] Vocational/ Retraining
- [ ] Transportation
- [x] Other
- [ ] Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE NURSE CASE MGMT

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

WORKER'S NAME IN FULL	Social Security Number (for ID only)	Claim Number
Last: Doe / First: John / Middle: A	123-45-6789	AA 00000

Address	Employer's Name
123 E 5th Ave	ABC Employer

City	State	ZIP	Reimburse Injured Worker	If yes, receipt required
Any City	WA	98512	☐ Yes ☒ No	

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	XXXXX XXXXXXXX MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _______/_______/_______

Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	1220M		Phone Calls						$XX.XX	X	01/31/11
01/01/11	xx	1221M		Visits						$XX.XX	X	01/31/11
01/01/11	xx	1222M		Case Planning						$XX.XX	X	01/31/11
01/01/11	xx	1223M		Travel/Wait						$XX.XX	X	01/31/11
01/01/11	xx	1224M		Mileage (enter total miles in units)						$ X.XX	X	01/01/11
01/01/11	xx	1225M		Expenses						$ X.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature

Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Nurse Case Manager's Name	0000000	0000000000	$ XX.XX

Address	Phone Number
123 E 5th Ave	(XXX) XXX-XXXX

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXXXX

Federal tax ID number	
XX-XXXXXXX ☒ EIN ☐ SSN	

Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

DO NOT WRITE IN SPACE > **SAMPLE OBESITY TREATMENT**

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☒ Other
- ☐ Home Health/ Nursing Home Services

WORKER'S NAME IN FULL			Social Security Number (for ID only)	Claim Number
Last Doe	First John	Middle A	123-45-6789	AA 00000
Address: 123 E 5th Ave			Employer's Name: ABC Employer	
City: Any City	State: WA	ZIP: 98512	Reimburse Injured Worker ☐ Yes ☒ No	If yes, receipt required
Date of Injury: MM-DD-YY	Name of referring physician or other source: XXXXX XXXXXXXX MD		Referring physician provider number / NPI: 0000000 / 0000000000	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _______/_______/_______
Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	97802		Medical Nutrition Thpy – Initial Assessment						$XX.XX	X	01/01/11
01/01/11	xx	97803		Medical Nutrition Thpy – Re-Assessment						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature
Bill date: MM / DD / YY
Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Provider's Name	0000000	0000000000	$ XX.XX
Address: 123 E 5th Ave			Phone Number: (XXX) XXX-XXXX
City: Any City	State: WA	ZIP + 4: 00000-0000	Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number: XX-XXXXXXX	☒ EIN ☐ SSN		Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

- [ ] Dental Services
- [ ] Glasses
- [ ] Medical Equipment/ Prosthetics-Orthotics
- [ ] Vocational/ Retraining
- [ ] Transportation
- [x] Other
- [ ] Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE > SAMPLE OCCUPATIONAL THERAPY

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

WORKER'S NAME IN FULL		Social Security Number (for ID only)	Claim Number
Last: Doe First: John Middle: A		123-45-6789	AA 00000
Address: 123 E 5th Ave		Employer's Name: ABC Employer	
City: Any City	State: WA ZIP: 98512	Reimburse Injured Worker: ☐ Yes ☒ No	If yes, receipt required
Date of Injury: MM-DD-YY	Name of referring physician or other source: XXXXX XXXXXXXX MD	Referring physician provider number / NPI: 0000000 / 0000000000	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _______/_______/_______
Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	xx	97003		Occupational Therapy Evaluation						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature
Bill date: MM / DD / YY
Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Provider's Name OT	0000000	0000000000	$ XX.XX
Address: 123 E 5th Ave			Phone Number: (XXX) XXX-XXXX
City: Any City	State: WA	ZIP + 4: 00000-0000	Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number: XX-XXXXXXX ☒ EIN ☐ SSN			
			Referral ID

STATEMENT FOR MISCELLANEOUS SERVICES

- [ ] Dental Services
- [x] Glasses
- [ ] Medical Equipment/ Prosthetics-Orthotics
- [ ] Vocational/ Retraining
- [ ] Transportation
- [ ] Other
- [ ] Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE > SAMPLE OPTICIAN

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

WORKER'S NAME IN FULL	Social Security Number (for ID only)	Claim Number
Last: Doe · First: John · Middle: A	XXX-XX-XXXX	AA 00000

Address	Employer's Name
123 E 5th Ave	ABC Employer

City	State	ZIP	Reimburse Injured Worker	
Any City	WA	98512	☐ Yes ☒ No	If yes, receipt required

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	XXXXX XXXXXXXX MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _______/_______/_______

Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	XX	XXXXX		XXXXXXXXXXXXXX						$XX.XX	X	01/01/11
01/01/11	XX	Xxxxx		XXXXXXXXXXXXXX						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature   Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Provider's Name	0000000	0000000000	$ XX.XX

Address	Phone Number
123 E 5th Ave	(XXX) XXX-XXXX

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXXXX

Federal tax ID number	Referral ID
XX-XXXXXXX ☒ EIN ☐ SSN	

STATEMENT FOR MISCELLANEOUS SERVICES

DO NOT WRITE IN SPACE > SAMPLE VOCATIONAL REHAB SERVICES

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

- ☐ Dental Services
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Transportation
- ☐ Home Health/ Nursing Home Services
- ☐ Glasses
- ☒ Vocational/ Retraining
- ☐ Other

WORKER'S NAME IN FULL — Last / First / Middle	Social Security Number (for ID only)	Claim Number
Doe / John / A	XXX-XX-XXXX	AA 00000

Address	Employer's Name
123 E 5th Ave	ABC Employer

City	State	ZIP	Reimburse Injured Worker	
Any City	WA	98512	☐ Yes ☒ No	If yes, receipt required

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	XXXXX XXXXXXXX MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _______/_______/_______
Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	XX	XXXXX		XXXXXXXXXXXXXX						$XX.XX	X	01/01/11
01/01/11	XX	XXXXX		XXXXXXXXXXXXXX						$XX.XX	X	01/01/11
01/01/11	XX	XXXXX		XXXXXXXXXXXXXXXX						$XX.XX	X	01/01/11
01/01/11	XX	XXXXX		XXXXXXXXXXXXXXXX						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Voc Rehab Counselor	0000000	0000000000	$ XX.XX

Address	Phone Number
123 E 5th Ave	(XXX) XXX-XXXX

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXXXX

Federal tax ID number: XX-XXXXXXX ☒ EIN ☐ SSN

Referral ID: XXXXXXXXXX

STATEMENT FOR MISCELLANEOUS SERVICES

☐ Dental Services
☐ Glasses
☐ Medical Equipment/ Prosthetics-Orthotics
☒ Vocational/ Retraining
☐ Transportation
☐ Other
☐ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE VOCATIONAL REHAB SERVICES

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

WORKER'S NAME IN FULL — Last: Doe; First: John; Middle: A

Social Security Number (for ID only): XXX-XX-XXXX

Claim Number: AA 00000

Address: 123 E 5th Ave

Employer's Name: ABC Employer

City: Any City; State: WA; ZIP: 98512

Reimburse Injured Worker ☐ Yes ☒ No — If yes, receipt required

Date of Injury: MM-DD-YY

Name of referring physician or other source: XXXXX XXXXXXXX MD

Referring physician provider number / NPI: 0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _______/_______/_______
Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	XX	XXXXX		XXXXXXXXXXXXX						$XX.XX	X	01/01/11
01/01/11	XX	XXXXX		XXXXXXXXXXXXX						$XX.XX	X	01/01/11
01/01/11	XX	XXXXX		XXXXXXXXXXXXX						$XX.XX	X	01/01/11
01/01/11	XX	XXXXX		XXXXXXXXXXXXXXX						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature
Bill date: MM / DD / YY
Remarks:

Provider or Supplier name: Voc Rehab Intern
Provider number: 0000000
NPI: 0000000000
Total Charge: $ XX.XX
Address: 123 E 5th Ave
Phone Number: (XXX) XXX-XXXX
City: Any City; State: WA; ZIP + 4: 00000-0000
Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number: XX-XXXXXXX ☒ EIN ☐ SSN
Referral ID: XXXXXXXXXX

STATEMENT FOR MISCELLANEOUS SERVICES

- [ ] Dental Services
- [ ] Glasses
- [ ] Medical Equipment/ Prosthetics-Orthotics
- [x] Vocational/ Retraining
- [ ] Transportation
- [ ] Other
- [ ] Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE VOCATIONAL REHAB SERVICES

Dept of Labor and Industries
Claims Section
PO Box 44269
Olympia WA 98504-4269

WORKER'S NAME IN FULL Last / First / Middle	Social Security Number (for ID only)	Claim Number
Doe John A	XXX-XX-XXXX	AA 00000

Address	Employer's Name
123 E 5th Ave	ABC Employer

City	State	ZIP	Reimburse Injured Worker	If yes, receipt required
Any City	WA	98512	☐ Yes ☒ No	

Date of Injury	Name of referring physician or other source	Referring physician provider number / NPI
MM-DD-YY	XXXXX XXXXXXXX MD	0000000 / 0000000000

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _______/_______/_______

Discharged _______/_______/_______

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
01/01/11	XX	XXXXX		XXXXXXXXXXXXXX						$XX.XX	X	01/01/11
01/01/11	XX	XXXXX		XXXXXXXXXXXXXX						$XX.XX	X	01/01/11

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Signature

Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	NPI	Total Charge
Voc Rehab Councelor Forensic	0000000	0000000000	$ XX.XX

Address	Phone Number
123 E 5th Ave	(XXX) XXX-XXXX

City	State	ZIP + 4	Your Patient's Account Number
Any City	WA	00000-0000	XXXXXXXXXXXX

Federal tax ID number: XX-XXXXXXX ☒ EIN ☐ SSN

Referral ID: XXXXXXXXXX