

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR HOME NURSING SERVICES

Instructions on next page

Worker Information (Please print)

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

Provider Information (Please print)

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

Billing Information

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

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

Worker Signature:

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

Provider Signature:

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

Signature (Required for worker reimbursement) Date

Signature Date

Instructions for completing the Statement for Miscellaneous Services:

Worker Information:

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

Provider Information:

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

Bill Information:

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

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

Place of Service Codes

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