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

STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

☐ Dental Service ☐ Glasses ☐ Home Health / Nursing Home ☐ Medical Equipment/ Prosthetics-Orthotics

☐ Transportation ☐ Vocational/Retraining ☐ Other: _____

Worker Information (Please print)

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

Provider Information (Please print)

Provider name			L&I provider number/NPI / Your Patient Account Number
Address			Federal Tax ID/Employer ID Number
City	State	ZIP	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

For glasses, is the old prescription available?
☐ Yes ☐ No

For inpatient services:
Date admitted:_____ Date discharged: _____

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing: No. of hrs/day	Home Nursing: Hourly/ Day rate	Charges	Units
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.

Signature (Required for worker reimbursement) Date

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 Date

Instructions for completing the Statement for Miscellaneous Services:

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

Worker Information:

Claim number	Give the 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/NPI	Give the provider's L&I provider number or provider's NPI.
Provider name	Write the provider's name as registered with L&I.
Provider address	Write the provider's physical address.
Your Patient Account Number	Write the number you use to identify your patient's account. This field is optional and not used by L&I.
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.
For glasses, is the old prescription available?	Check the appropriate box.
For inpatient services	Write date of admission and the date of discharge in the mm/dd/yy format.

Use one line for each service provided. Complete each applicable field.

From date of service	Starting date of service.
To date of service	Ending date of service.
POS	Place of service. See the list below for the appropriate two-digit code.
Proc Code	Procedure code.
Mod	Modifier code if applicable.
Diagnosis	Diagnosis code. Enter the primary diagnosis code for each service.
Description	Give a brief description of services provided.
Dental tooth number	Tooth number dental services were provided for.
Home nursing	Give the number of hours you are billing for. Give your hourly or daily rate for your services.
Charges	Enter the charge for each service provided.
Units	Enter the number of units for service.

Place of Service Codes

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