

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

Sample
 Interpreter
 Billing for 1
 client served at
 2 appointments
 in 1 day



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) Doe, John A			Claim No. Y000000
Home address (not PO Box) 114 Foxtail Lane			Date of injury DD/MM/YY
City Any City	State WA	Apt # 5F	Social Security No. (for ID only) 111-11-1111
		ZIP 99999	Phone no. 111-111-1111

Provider Information (Please print)

Provider name Interpreter's Name			L&I provider number/NPI Interpreter's Provider Number
Address Interpreter's Address			Your Patient Account Number
City Any City	State WA	ZIP 99999-9999	Federal Tax ID/Employer ID Number XXXXXXXXXXXXXXXXXXXX
Name of referring physician or other source James Jones, MD		Referring provider number/NPI	Phone no. Interpreter's phone number
			Referral ID

Billing Information

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

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	11/1/08	11/1/08	XX	9989M				Individual Interpretation				\$xx.xx	00
2	11/1/08	11/1/08	XX	9986M				Mileage				\$xx.xx	00
3	11/1/08	11/1/08	XX	9989M				Individual Interpretation				\$xx.xx	00
4	11/1/08	11/1/08	XX	9986M				Mileage				\$xx.xx	00
5													
6													
7													
8													
9													
10													

CHARGES: Charge your usual and customary fees

Units:
Individual Interpretation:
 Units = Number of minutes

Mileage:
 Units = Number of miles

Total Charge
 \$XX.XX

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.

 Interpreter's signature MM/DD/YY
 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 | 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 | |

