

STATEMENT FOR CRIME VICTIM MISCELLANEOUS SERVICES



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

- | | |
|--|---|
| <input type="checkbox"/> Dental Services | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Medical Equipment/
Prosthetics-Orthotics | <input type="checkbox"/> Vocational /
Retraining |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Home Health/
Nursing Home Services | |

**DO NOT
WRITE IN
SPACE** ➤

Claimant's full name, Last	First	Middle	SSN (ID only)	Claim Number
Mailing address			Date of Birth	Date of Injury
City	State	ZIP	Reimburse claimant <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount paid \$
Name of referring physician or other source			Referring physician provider number / NPI	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM, DSM III, or DSM IV) Designate left or right when applicable

For glasses, advise if old Rx was available
 Yes No

Give hospitalization date 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		GLASSES				CHARGES \$ C	Unit	T O DATE OF SERVICE
						No. of hrs/day	Hourly/Day rate	OLD RX OD	NEW RX OS	OD	OS			
1.														
2.														
3.														
4.														
5.														
6.														
7.														

Submission of this bill certifies the material furnished, service provided, expense 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: _____	Provider or Supplier name	Provider Number	NPI	Taxonomy	
	Address				Total Charge
	City	State	ZIP+4		Phone Number
	Federal tax ID number	<input type="checkbox"/> EIN <input type="checkbox"/> SSN		Your Patient's Account Number	
Amount paid by Primary Insurance \$	Name of Primary Insurance Company				

PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS OR YOUR BILL MAY BE DENIED.

INSTRUCTIONS FOR COMPLETING CRIME VICTIMS MISCELLANEOUS SERVICES FORM

1. Place an "X" in the box next to the type of service for which you are billing.
2. **CLAIMANT'S NAME:** Claimant's full name, last name first.
3. **SOCIAL SECURITY NUMBER:** Record claimant's social security number. It is helpful when the claim number is wrong and the claimant's name is common.
4. **CLAIM NUMBER:** For the claimant receiving services. Billings cannot be processed without the claim number. Crime Victim claim numbers are six digits preceded by a "V", or five digits preceded by a "VA, VB, VC, VH, VJ, VK or VL".

Send bills for Crime Victims claims to:

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5. **ADDRESS:** The claimant's most current address.
6. **DATE OF BIRTH:** Enter the claimant's date of birth.
7. **DATE OF INJURY:** This is important and must be included. One claimant may have several claims so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
8. **REIMBURSE CLAIMANT:** Place an "X" in the applicable box. If payment should be made to the claimant, indicate the amount paid.
9. **NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services. (Not applicable for Vocational Services billing.)
10. **REFERRING PHYSICIAN PROVIDER NUMBER / NPI:** The Crime Victims Compensation Program provider account number or NPI of the referring physician.. The number may be obtained from the referring physician. (Not applicable for Vocational Services billing.)
11. **DIAGNOSIS:** Indicate both the ICD-9-CM, DSM III or DSM IV number and the narrative diagnosis for all conditions treated. Designate left or right side of body, when applicable. The diagnosis presented must be specific. (Not applicable for Vocational Services billing.)
12. **FOR GLASSES:** Indicate by placing an "X" in the appropriate box.
13. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
14. **REFUND CERTIFICATION - FOR CLAIMANT REIMBURSEMENT:** Signature of the claimant who received the care.
15. **ITEMIZATION OF SERVICES AND CHARGES:**
 - A. **DATE(S) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (e.g., home care, attendant care, equipment rental, etc.) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
 - B. **PLACE OF SERVICE:** Place of Service (POS) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
 - C. **PROCEDURE CODE:** Identifies the procedures used. Procedure codes can be found in the **Medical Aid Rules and Maximum Fee Schedule** distributed by the Department of Labor and Industries.
 - D. **CODE MODIFIER:** A modifier provides the means by which the reporting physician can indicate that a performed service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modifier code number" (including the hyphen) after the usual procedure number.
 - E. **DENTAL:** To be used for dental services only.
Tooth Number: Identify dental services provided by placing the specific tooth number in the appropriate box.
 - F. **HOME NURSING:** To be used for home care only
Number of Hours or Days: Identify the number of hours or the number of days that the home care services were provided.
Hourly or Daily Rate: Record the rate charged (by the hour or day) for the home care services provided.
 - G. **GLASSES:** To be used for glasses repair or replacement only.
Old Rx (OD and OS): If the old prescription is available, specify for both the left and right eyes.
New Rx (OD and OS): Specify the new prescription for both the left and right eyes.
 - H. **CHARGES:** Charges for services provided.
 - I. **UNIT:** The sum total of services provided for days, units, or miles, etc.
16. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** The provider's or supplier's name and current address. If any of the information changes, notify Provider Accounts immediately. (Indicating a new address on the bill **will not** change the department's record of address for the provider.)
17. **PROVIDER NUMBER:** Enter Crime Victims Compensation Program provider account number.
18. **NPI:** Enter the national provider identifier.
19. **TAXONOMY:** Enter the ten-digit taxonomy code.
20. **TOTAL CHARGE:** Total of **all** charges for services provided.
21. **YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's account.
22. **FEDERAL TAX IDENTIFICATION NUMBER:** Enter provider's IRS (Internal Revenue Service) federal tax identification number. Indicate by marking box whether federal tax ID number is EIN or SSN.
23. **AMOUNT PAID BY PRIMARY INSURANCE :** As Crime Victims Compensation is a secondary insurer, private or public insurance must be billed first. Enter amount paid by private or public insurance. Attach a copy of the explanation of benefits for payments and denials.
24. **NAME OF PRIMARY INSURANCE COMPANY:** Enter name of private or public insurance company making payment on behalf of the claimant.

REQUIRED ATTACHMENTS:

The following attachments **must be** submitted with billings for appropriate services:

- | | | | |
|-------------------|----------------------|-----------------------------|---------------------------------------|
| 1. X-ray findings | 3. Office Notes | 5. Emergency Room reports | 7. Cost invoice of supplies furnished |
| 2. Lab reports | 4. Operative reports | 6. Diagnostic Study reports | 8. Consultation reports |

Each attachment must have the corresponding claim number listed in the upper right corner of the attachment.

DUE TO THE FACT THAT CRIME VICTIMS' BILL RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.

The following attachment is **not** acceptable: Office Visit Slips

REBILLS: If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill: same charges, codes and billing dates. Please indicate "**Rebill**" on the bill. Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

PLACE OF SERVICE (POS) 03. School 04. Homeless Shelter 05. Indian Health Service Free-standing Facility 06. Indian Health Service Provider-based Facility 08. Tribal 638 Provider-based Facility 09. Correctional Facility	11. Office 12. Patient's Home 15. Mobile Unit 20. Urgent Care Facility 21. Inpatient Hospital 22. Outpatient Hospital 23. Emergency Rm - Hospital 24. Ambulatory Surgical Ctr 25. Birthing Ctr 26. Military Trmt Facility	31. Skilled Nursing Facility 32. Nursing Facility 33. Custodial Care Facility 34. Hospice 41. Ambulance - Land 42. Ambulance - Air or Water 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 Facility 56. Psychiatric Residential Trmt Ctr 60. Mass Immunization Ctr 61. Comprehensive Inpatient Rehabilitation Facility 65. End Stage Renal Disease Trmt Facility 71. State or Local Public Health Clinic 72. Rural Hlth Clinic 81. Independent Laboratory 99. Other Unlisted Facility
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