

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



Statement For Retraining And Job Modification Services

Worker Information (Please print)

Name (Last, First, Middle Initial)			Claim No.
Home address		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			Federal Tax ID
City	State	ZIP	Phone no.

Vocational Rehabilitation Counselor Information (Please print)

Vocational Rehabilitation Counselor Name		Referral ID
		VRC ID (L&I provider number)

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	TOS	Procedure Code	Description of Services or Supplies	Units	Charges
1			99	V				
2			99	V				
3			99	V				
4			99	V				
5			99	V				
6			99	V				
7			99	V				
8			99	V				
9			99	V				
10			99	V				
							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 Retraining and Job Modification 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.
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.

Vocational Rehabilitation Counselor Information

Referral ID	Write the referral ID.
VRC ID	Write the VRC ID. This is the L&I provider number for the VRC.
Vocational Rehabilitation Counselor Name	Write the vocational rehabilitation counselor's name as registered with L&I.

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.
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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.
Procedure code	Refer to the list of codes below. List the appropriate code. One code per line.
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 for all of the charges on the bill.

Job Modification/Pre-Job Accommodation Codes:	Lodging and Retraining Codes:	Retraining Codes:	Retraining Transportation Codes:
0380R Job Modification equipment 0385R Pre-job accommodation equipment 0389R Job Modification/Pre-job accommodation consultation 0391R Travel/Wait 0392R Mileage 0393R Ferry	R0360 Board (food) and utilities R0370 Rent 0375R One-time relocation fee (for life of claim)	R0310 Tuition, training fee R0312 Supplies R0315 Equipment, tools R0320 Exams, license fee R0340 Books R0350 Other R0390 Child care services	0302R Parking 0303R Bridge and ferry toll 0304R Commercial transportation