



Washington State Department of
Labor & Industries
Workers' Compensation Services

Retraining and Job Modification Expenses

Billing Instructions

**LABOR AND INDUSTRIES BILLING INSTRUCTIONS
STATEMENT FOR RETRAINING
AND JOB MODIFICATION SERVICES
F245-030-000**

The [STATEMENT FOR RETRAINING AND JOB MODIFICATION SERVICES](http://www.lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/default.asp) (F245-030-000) must be used when billing for retraining and job modification services provided to industrially injured/ill workers. Department bill forms are furnished at no charge to providers and can be obtained by calling your local [L&I field service office](#). Providers outside Washington State may contact the Provider Hotline at 1-800-848-0811. When ordering, give your full name, address, L&I provider number, quantity needed, and the L&I form number, F245-030-000. Additional billing information can be located on the Lni web site <http://www.lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/default.asp>

It is preferred that bills be submitted on ORIGINAL (not photo copies) Retraining and Job Modification Services forms.

To request changes on a bill already paid or partially paid by the department, submit a [Providers Request for Adjustment](#) form (F245-183-000) Providers can send a new bill for services that were totally denied. Providers have 1 (one) year from the date of service to submit an adjustment or a rebill.

L&I PROVIDER ACCOUNT NUMBER

In order to treat and receive payment for the services you provide to a Washington worker or crime victim, you must have an active L&I provider account number ([WAC 296-20-015](#)).

How do I obtain an L&I Provider account number?

You can apply for an L&I provider account number by completing the [Provider Account Application and Form W-9](#) (F248-011-000). You may find provider accounts forms at <http://www.becomeprovider.lni.wa.gov/>, or request them by contacting the L&I Provider Accounts section at 360-902-5140.

Fax completed applications to 360-902-4484, or mail them to the address on the form.

Where do I mail my billing forms?

State Fund Bills:

Please **do not fax** State Fund bills. Mail State Fund billing forms to Labor & Industries at the following address:

**Department of Labor & Industries
PO Box 44269
Olympia WA 98504-4269**

SELF-INSURANCE

Send self-insured claims directly to the self-insured employer (SIE) or their third party administrator (TPA). For a list of SIE/TPAs and their contact information, go to:

www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp.

Table of Contents

Provider Specific Instructions3

Statement for Retraining and Job Modification Services form4-5

Instructions on completing the “Statement for Retraining and Job Modification Services” form6-7

 Sample Bill – Tuition and Training Costs8

 Sample Bill – Rent 9

 Sample Bill – Groceries & Utilities..... 10

 Sample Bill – Child Care Services.....11

 Sample Bill – Job Modification..... 12

Job Modification Assistance Application 13-15

Pre-Job Accommodation Assistance Application 16-18

PROVIDER SPECIFIC INSTRUCTIONS

RETRAINING PROCEDURE CODE:

- R0310 Tuition, Training fees
- R0312 Supplies-are consumable goods such as: paper, pens, CDs, or disposable gloves
- R0315 Equipment, Tools-such as: calculator, software, survey equipment, welding gloves, mechanic tools
- R0320 Exam, License Fee
- R0340 Books
- R0350 Other- includes professional uniforms, including uniform shoes required for training, and other items that don't fit the more defined categories
- R0390 Child Care Services (Licensed)

LODGING & RELOCATION:

- R0360 Board (Food) and Utilities
- R0370 Rent
- 0375R One-Time Relocation Fee (for lifetime of claim)

TRANSPORTATION:

- 0302R Parking
- 0303R Bridge & Ferry Tolls
- 0304R Commercial Transportation

JOB MODIFICATION PROCEDURE CODES:

The following codes are payable to authorized equipment vendors:

Code	Description	Activities	Maximum Fee
0380R	Job modification Requires prior authorization	Equipment/Tools <ul style="list-style-type: none"> • Installation • Set up • Basic training in use • Delivery (includes mileage) • Tax • Custom Modification/Fabrication Work area modification/reconfiguration	Maximum allowable for 0380R is \$5,000 per job or job site.
0385R	Pre-job accommodation Requires prior authorization	Equipment/Tools <ul style="list-style-type: none"> • Installation • Set up • Basic training in use • Delivery (includes mileage) • Tax • Custom Modification/Fabrication Work/Training area modification/reconfiguration	Maximum allowable for 0385R is \$5,000 per claim. Combined costs of 0380R and 0385R for the same return to work goal can't exceed \$5,000.

Additional information is available at <http://www.Lni.wa.gov/ClaimsIns/Providers/Vocational/Tools/PreJob/default.asp>

A properly completed and signed [Job Modification Assistance application](#) and [Pre-job Accommodation Assistance application](#) must accompany billings for job and pre-job modifications. For billing questions or assistance in completing the [Statement for Retraining and Job Modification](#) Services form please call 1-800-848-0811 or in Olympia (360) 902-6500.



STATEMENT FOR RETRAINING AND JOB MODIFICATION SERVICES

**DO NOT
 WRITE IN >
 SPACE**

**Instructions for completing form on
 the reverse side**

Worker's Name LAST			FIRST	MI	Claim No.
Worker's home address (not PO Box)				Apt #	Date of injury
City	State	ZIP + 4		Reimburse Injured Worker	If yes, receipt required
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please indicate Vocational Rehabilitation Counselors name and telephone number

REFUND CERTIFICATION

These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the back of this form.

VRC ID	REFERRAL ID
--------	-------------

INJURED WORKER'S SIGNATURE:

X

Itemization of Service and Charges

FROM DATE OF SERVICE	P O S	* T O S	PROCEDURE CODE	DESCRIBE SERVICES, OR SUPPLIES FURNISHED	CHARGES \$ ¢	UNIT	TO DATE OF SERVICE
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

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. PROVIDER SIGNATURE: Bill date:	Provider name	Provider number	Total Charge	
	Address		Phone Number	
	City	State	ZIP+4	Your Client's Account Number
	Federal tax ID Number			
	<input type="checkbox"/> EIN <input type="checkbox"/> SSN			

L&I must receive this statement within 12 months of the date of service or claim allowance.

* Place of Service (POS), Type of Service (TOS) and Procedure codes on back

Department bill forms are furnished at no charge to the vendor, and may be obtained at: <http://www.lni.wa.gov/FormPub/results.asp?Keyword=provider+billing&Submit=Search> or by calling the local department service location.

INSTRUCTIONS FOR COMPLETING RETRAINING AND JOB MODIFICATION SERVICES FORM (Retraining & Job mods only)
IMPORTANT: Retraining mileage must be billed on a Travel Expense Voucher form for injured worker reimbursement. Please call the provider hotline at 1-800-848-0811 for the correct reimbursement form, F245-145-000.

CLAIM NUMBER: For the injured worker receiving services.

STATE FUND INDUSTRIAL INSURANCE

Claim numbers are six digits, beginning with a "B, C, F, G, H, J, K, L, M, N, P, X, Y or double alpha followed by 5 digits."
Send bills for Industrial Insurance claims to:

Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

CRIME VICTIMS

Claim numbers are six digits beginning with a "V", or five digits preceded by a "VA, VB, VC, VH, VJ, VK, VL or VS."
Send bills for Crime Victims claims to:

Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

SELF-INSURANCE

Claim numbers are six digits beginning with an "S, T, W", or double alpha (SA-SZ, TA-TZ, WA-WZ). Department of Energy claims are now Self-Insured. Claim numbers are seven digits beginning with "7, 8 or 9." Send bills to the employer or their service company.

INJURED WORKER'S NAME: Injured worker's full name, last name first.

DATE OF INJURY: This is important and must be included. One worker may have several claims, so it is vital the proper claim be identified and charged for services provided.

HOME ADDRESS: The injured worker's most current address (not PO Box).

SOCIAL SECURITY NUMBER: Record injured worker's social security number. It is helpful when the claim number is wrong and the worker's name is common.

REIMBURSE INJURED WORKER: Place an "X" in applicable box.

VRC ID: L&I provider ID of Vocational Rehabilitation Counselor.

REFERRAL ID: VRC's L&I referral number.

WORKER'S SIGNATURE: Worker's signature is required for claimant reimbursements. Forms not signed will be returned.

VOCATIONAL REHAB COUNSELOR'S NAME AND TELEPHONE NUMBER

ITEMIZATION OF SERVICES AND CHARGES: Receipts required for worker reimbursement.

FROM DATE(S) OF SERVICE: Record the date for each service provided (Note: for food only, a separate line is required for each receipt date).

PLACE OF SERVICE (POS): Put code 99 in this box.

TYPE OF SERVICE (TOS): Put type of service code "V" in this box.

PROCEDURE CODE: Please refer to the list of procedure codes below. Choose a code that best describes your service and enter it in the box.

DESCRIBE SERVICES OR SUPPLIES FURNISHED: Description of service(s) provided.

CHARGES: Charges for service provided. Itemized, dated & business stamped **RECEIPTS REQUIRED FOR WORKER**

REIMBURSEMENT. For food receipts, items purchased must have a description. (Please send receipt copies. Keep your original).

UNIT: Number of days/units for the service billed on each line.

TO DATE(S) OF SERVICE: Record the date for each service provided. (Note: for food only, a separate line is required for each receipt date).

PROVIDER SIGNATURE: Signature required for any provider billings. Forms not signed will be returned.

PROVIDER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER: If any of this information changes, call 1-800-848-0811 immediately. (Simply indicating a new address on the bill **will not** change L&I's record of address for the provider.) For further information, find us at: www.lni.wa.gov/claimsinsurance/providerpay/billing/provider

PROVIDER NUMBER: Identification number designated by the Department of Labor and Industries for the provider.

TOTAL CHARGE: Total of all charges for services provided.

YOUR CLIENT'S ACCOUNT NUMBER: The number used for providers to identify their client's account.

FEDERAL TAX I.D. NUMBER: The provider taxpayer identification number for IRS (Internal Revenue Service) reports.

CODES

JOB MODIFICATION PROCEDURES CODES:

0380R Job Modification
0385R Pre-Job Accommodation
Equipment

RETRAINING PROCEDURE CODES:

R0310 Tuition, Training Fees
R0312 Supplies
R0315 Equipment, Tools
R0320 Exam, License Fee
R0340 Books
R0350 Other
R0390 Child Care Services

RETRAINING TRANSPORTATION CODES:

0302R Parking
0303R Bridge and Ferry Tolls
0304R Commercial Transportation

LODGING & RELOCATION:

R0360 Board (Food) and Utilities
R0370 Rent
0375R One-Time Relocation Fee
(for life-time of claim)

COMPLETING THE “STATEMENT FOR RETRAINING AND JOB MODIFICATION SERVICES” FORM

The Department of Labor and Industries and service providers are joined in a cooperative process for payment of provider billings. In order to process the billings in a timely manner, the billings must be completed as described. Improperly completed bill forms may be returned to the provider for completion/correction and resubmission.

Completed bill forms **MUST** be typed or printed and be clearly legible. Bills must be submitted on **ORIGINAL** (not photocopies or facsimiles) Statement for Retraining and Job Modification Services forms. All boxes on the form other than those identified, as “not applicable” **MUST** be completed to ensure correct bill adjudication.

All boxes on the form other than those identified, as “not applicable” **must** be completed in order to ensure correct bill adjudication.

1. **WORKER’S NAME:** Enter the worker’s last name, first name and middle name or initial.
2. **SOCIAL SECURITY NUMBER:** Enter worker’s social security number. This information will assist us in identifying the injured worker’s claim number if the claim number is missing or invalid.
3. **CLAIM NUMBER:** Enter the department-assigned claim number for the injury/condition being treated. Omission of this number will result in denial of payment.

Claim numbers are alpha-numeric, consisting of seven characters. The letter identifies the funding source, which is listed below.

STATE FUND INDUSTRIAL INSURANCE

SF claim numbers are alpha-numeric, consisting of 7 characters. They begin with B, C, F, G, H, J, K, L, M, N, P, X, or Y followed by 6 digits or double alpha (e.g. AA, AB) followed by 5 digits

Send bills for State Fund claims to:

Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

CRIME VICTIM COMPENSATION PROGRAM

Crime Victim claim numbers are either six digits preceded by a “V”, or five digits preceded by a VA-VZ.

Send all bills for Crime Victims claims to:

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

SELF-INSURANCE

Self-Insurance claim numbers are six digits preceded by an S, T, W, or double alpha followed by 5 digits (SA-SZ, TA-TZ, WA-WZ). Self-Insurance claims should be sent directly to the employer or their service company. Department bill forms, Self-Insured forms, or other forms acceptable to the Self-Insurer may be used. If you have any questions about Self-Insured billing, please call the worker’s employer or Labor and Industries’ Self-Insurance section at (360) 902-6901.

4. **ADDRESS:** Enter worker’s current address.

5. **REIMBURSE INJURED WORKER:** Check applicable box indicating whether the worker has paid for the services.
6. **DATE OF INJURY/ILLNESS:** Enter the date of injury. This date positively identifies each claim. It is important and must be included. A worker may have several claims; therefore, it is vital the proper claim be identified and charged for services provided.
7. **VRC ID and REFERRAL ID:** Please enter vrc ID # and Referral ID #
8. **ITEMIZATION OF SERVICES AND CHARGES:** Receipts required for worker reimbursement.
 - A. **FROM DATE OF SERVICE:** Record the date for each service provided (Note: for food only, a separate line is required for each receipt date).
 - B. **PLACE OF SERVICE (POS):** Put code 99 in this box.
 - C. **TYPE OF SERVICE:** Put type of service “V” in this box.
 - D. **PROCEDURE CODE:** Please refer to the list of procedure codes on the next page. Choose a code that best describes your service and enter it in the box.
 - E. **DESCRIBE SERVICES OR SUPPLIES FURNISHED:** Description of service(s) provided.
 - F. **CHARGES:** Charges for services provided. Original, itemized, dated & business stamped **RECEIPTS REQUIRED FOR WORKER REIMBURSEMENT**. For food receipts, items purchased must have a description.
 - G. **UNIT:** Number of days/units for the service billed on each line.
 - H. **TO DATE(s) OF SERVICE:** Record the date of each service provided (Note: for food only, a separate line is required for each receipt date).
9. **PROVIDER’S SIGNATURE:** Signature required for any provider billings. Forms not signed will be returned.
10. **PROVIDER’S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** If any of this information changes, call 1-800-848-0811 immediately. (*Simply indicating a new address on the bill **will not** change L&I’s record of address for the provider.*) For further information, find us at:
www.Lni.wa.gov/claimsinsurance/providerpay/billing/provider
11. **PROVIDER NUMBER:** Identification number designated by the Department of Labor and Industries for the provider.
12. **TOTAL CHARGE:** Total of **all** charges for services provided.
13. **YOUR CLIENT’S ACCOUNT NUMBER:** The number used for providers to identify their client’s account



STATEMENT FOR RETRAINING AND JOB MODIFICATION SERVICES

SAMPLE: TUITION & TRAINING COSTS

DO NOT
 WRITE IN >
 SPACE

Instructions for completing form on
 the reverse side

Worker's name Doe, John A		Claim No. Y 0000000
Worker's home address (not PO Box) 114 Foxtail Lane		Date of injury mm/dd/yy
City Any City	State WA	Social Security No. (for ID only) 123-45-6789
ZIP + 4 00000-0000		Reimburse Injured Worker <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Please indicate Vocational Rehabilitation Counselors name and telephone number A to Z Voc Rehab Inc.		REFUND CERTIFICATION These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the back of this form. INJURED WORKER'S SIGNATURE: X
VRC ID	REFERRAL ID	

Itemization of Service and Charges

FROM DATE OF SERVICE	P O S	* T O S	PROCEDURE CODE	DESCRIBE SERVICES, OR SUPPLIES FURNISHED	CHARGES \$ ¢	UNIT	TO DATE OF SERVICE
1. 01/02/10	99		R0310	Tuition	\$XX.XX	X	01/31/10
2. 01/02/10	99		R0340	Books	\$XX.XX	X	01/31/10
3. 01/02/10	99		R0312	Supplies	\$XX.XX	X	01/31/10
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

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. PROVIDER SIGNATURE: _____ Bill date: _____ X XXXXXXXXXXXXXXXXXXXX mm dd / yy	Provider name Provider's Name	Provider number 0000000	Total Charge \$XX.XX	
	Address 123 Retraining Lane SE		Phone Number 111-111-1111	
	City Any City	State WA	ZIP+4 00000-0000	Your Client's Account Number XXXXXXXXXXXX
	Federal tax ID number XX-XXXXXXX	<input checked="" type="checkbox"/> EIN	<input type="checkbox"/> SSN	

L&I must receive this statement within 12 months of the date of service or claim allowance.

* Place of Service (POS), Type of Service (TOS) and Procedure codes on back



STATEMENT FOR RETRAINING AND JOB MODIFICATION SERVICES

SAMPLE: RENT

DO NOT
 WRITE IN >
 SPACE

Instructions for completing form on
 the reverse side

Worker's name Doe, John A		Claim No. Y 0000000
Worker's home address (not PO Box) 114 Foxtail Lane Apt #		Date of injury mm/dd/yy
City Any City State WA ZIP + 4 00000-0000	Social Security No. (for ID only) 123-45-6789	
Please indicate Vocational Rehabilitation Counselors name and telephone number A to Z Voc Rehab Inc.		Reimburse Injured Worker <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
VRC ID	REFERRAL ID	REFUND CERTIFICATION These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the back of this form. INJURED WORKER'S SIGNATURE: X

Itemization of Service and Charges

FROM DATE OF SERVICE	P O S	* T O S	PROCEDURE CODE	DESCRIBE SERVICES, OR SUPPLIES FURNISHED	CHARGES \$ ¢	UNIT	TO DATE OF SERVICE
1 01/01/10	99		R0370	Rent	\$XXX.XX	X	01/31/10
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

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. PROVIDER SIGNATURE: _____ Bill date: _____ X XXXXXXXXXXXXXXXXXXXX mm dd / yy	Provider name Provider's Name	Provider number 0000000	Total Charge \$XXX.XX
	Address 123 Retraining Lane SE		Phone Number 111-111-1111
	City Any City State WA ZIP+4 00000-0000	Your Client's Account Number XXXXXXXXXXXX	
	Federal tax ID number XX-XXXXXXX <input checked="" type="checkbox"/> EIN <input type="checkbox"/> SSN		

L&I must receive this statement within 12 months of the date of service or claim allowance.

* Place of Service (POS), Type of Service (TOS) and Procedure codes on back



STATEMENT FOR RETRAINING AND JOB MODIFICATION SERVICES

SAMPLE: GROCERIES & UTILITIES

DO NOT
 WRITE IN >
 SPACE

Instructions for completing form on
 the reverse side

Worker's name Doe, John A		Claim No. Y 0000000
Worker's home address (not PO Box) 114 Foxtail Lane		Date of injury mm/dd/yy
City Any City	State WA	Social Security No. (for ID only) 123-45-6789
	ZIP + 4 00000-0000	Reimburse Injured Worker <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Please indicate Vocational Rehabilitation Counselors name and telephone number A to Z Voc Rehab Inc.		REFUND CERTIFICATION These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the back of this form. INJURED WORKER'S SIGNATURE: X
VRC ID	REFERRAL ID	

Itemization of Service and Charges

FROM DATE OF SERVICE	P * T O * O S * S	PROCEDURE CODE	DESCRIBE SERVICES, OR SUPPLIES FURNISHED	CHARGES \$ ¢	UNIT	TO DATE OF SERVICE
1. 01/01/10	99	R0360	Groceries	\$XX.XX	X	01/01/10
2. 01/07/10	99	R0360	Groceries	\$XX.XX	X	01/07/10
3. 01/01/10	99	R0360	Utilities	\$XX.XX	X	01/31/10
4.						
5.			Note: For food only a separate line is required for each receipt date.			
6.						
7.			PLEASE ATTACH RECEIPTS			
8.						
9.						
10.						
11.						
12.						

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. PROVIDER SIGNATURE: _____ Bill date: _____ X XXXXXXXXXXXXXXXX mm dd / yy	Provider name Provider's Name	Provider number 0000000	Total Charge \$XX.XX	
	Address 123 Retraining Lane SE		Phone Number 111-111-1111	
	City Any City	State WA	ZIP+4 00000-0000	Your Client's Account Number XXXXXXXXXXXX
	Federal tax ID number XX-XXXXXXX	<input checked="" type="checkbox"/> EIN	<input type="checkbox"/> SSN	

L&I must receive this statement within 12 months of the date of service or claim allowance.

* Place of Service (POS), Type of Service (TOS) and Procedure codes on back



STATEMENT FOR RETRAINING AND JOB MODIFICATION SERVICES

SAMPLE: CHILD CARE SERVICES

DO NOT
 WRITE IN >
 SPACE

Instructions for completing form on
 the reverse side

Worker's name Doe, John A		Claim No. Y 000000
Worker's home address (not PO Box) 114 Foxtail Lane		Date of injury mm/dd/yy
City Any City	State WA	Social Security No. (for ID only) 123-45-6789
ZIP + 4 00000-0000		Reimburse Injured Worker <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Please indicate Vocational Rehabilitation Counselors name and telephone number A to Z Voc Rehab Inc.		REFUND CERTIFICATION These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the back of this form. INJURED WORKER'S SIGNATURE: X
VRC ID	REFERRAL ID	

Itemization of Service and Charges

FROM DATE OF SERVICE	P O S	* T O S	PROCEDURE CODE	DESCRIBE SERVICES, OR SUPPLIES FURNISHED	CHARGES \$ ¢	UNIT	TO DATE OF SERVICE
1. 01/02/10	gg		R0390	Child Care Services	XXX.XX	X	01/31/10
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

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. PROVIDER SIGNATURE: _____ Bill date: _____ X xxxxxxxxxxxxxxxxxxxx mm dd / yy	Provider name Provider's Name	Provider number 0000000	Total Charge \$XXX.XX	
	Address 123 Retraining Lane SE		Phone Number 111-111-1111	
	City Any City	State WA	ZIP+4 00000-0000	Your Client's Account Number
	Federal tax ID number XX-XXXXXXX	<input checked="" type="checkbox"/> EIN	<input type="checkbox"/> SSN	XXXXXXXXXX

L&I must receive this statement within 12 months of the date of service or claim allowance.

* Place of Service (POS), Type of Service (TOS) and Procedure codes on back



STATEMENT FOR RETRAINING AND JOB MODIFICATION SERVICES

SAMPLE: JOB MODIFICATION

DO NOT
 WRITE IN >
 SPACE

Instructions for completing form on
 the reverse side

Worker's name Doe, John A		Claim No. Y 000000
Worker's home address (not PO Box) 114 Foxtail Lane Apt #		Date of injury mm/dd/yy
City Any City	State WA	Social Security No. (for ID only) 123-45-6789
ZIP + 4 00000-0000		Reimburse Injured Worker <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Please indicate Vocational Rehabilitation Counselors name and telephone number A to Z Voc Rehab Inc.		REFUND CERTIFICATION These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the back of this form. INJURED WORKER'S SIGNATURE: X
VRC ID	REFERRAL ID	

Itemization of Service and Charges

FROM DATE OF SERVICE	P O S	* T O S	PROCEDURE CODE	DESCRIBE SERVICES, OR SUPPLIES FURNISHED	CHARGES \$ ¢	UNIT	TO DATE OF SERVICE
1. 01/31/10	99		R0380	Ergonomic Chair	\$XXX.XX	X	01/31/10
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

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. PROVIDER SIGNATURE: _____ Bill date: mm dd / yy X XXXXXXXXXXXXXXXX	Provider name Provider's Name	Provider number 0000000	Total Charge \$XXX.XX	
	Address 123 Retraining Lane SE		Phone Number 111-111-1111	
	City Any City	State WA	ZIP+4 00000-0000	Your Client's Account Number XXXXXXXXXXXX
	Federal tax ID number XX-XXXXXXX	<input checked="" type="checkbox"/> EIN	<input type="checkbox"/> SSN	

L&I must receive this statement within 12 months of the date of service or claim allowance.

* Place of Service (POS), Type of Service (TOS) and Procedure codes on back

Mail completed application form to:
 Department of Labor & Industries
 Claims Section
 PO Box 44291
 Olympia WA 98504-4291



JOB MODIFICATION ASSISTANCE APPLICATION

One vendor per application form

	Date of injury	Claim number
Injured worker's name	Accepted diagnosis	
Vocational counselor/job modification consultant		Provider number
Firm's name		Phone number
Address		Fax number
City	State	ZIP+4

Worker's Job title	
Employer name	Phone number

RESTRICTIONS	DESCRIPTION OF JOB MODIFICATION

ITEMIZATION OF COSTS: Equipment _____ Tools _____ Other _____ Assembly, installation & delivery _____ Tax _____ Total \$ _____ Employer's portion of costs _____ State Fund or Self-Insured portion of costs _____	REQUIRED DOCUMENTATION <input type="checkbox"/> Job modification narrative or consultation report <p style="text-align: center;">AND</p> <input type="checkbox"/> Ownership agreement <p style="text-align: center;">AND</p> <input type="checkbox"/> Bids (2 bids if single item over \$2,500)	Labor and Industries (L&I) provider number required for payment. If equipment vendor does not have a L&I provider number – Call: Provider Accounts (360) 902-5140 For payment, submit bill on pink "Statement for Retraining and Job Modification Services" form (F245-030-000). Attach copy of approved application.
	Vendor name _____	
	Address _____	
	City _____	State _____ ZIP+4 _____
	Provider number _____	Phone number _____

Date _____	Vocational counselor or consultant signature _____	Employer signature (if contributed to costs) _____
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For Dept Use Only	<input type="checkbox"/> Approve	<input type="checkbox"/> Authorization code (0380R) _____ entered on AUTH	<input type="checkbox"/> Authorization amount _____ entered on CLOG	<input type="checkbox"/> Disapprove
Date _____	Signature authority _____			

Ownership Agreement for Tools and Equipment Purchased as a Job Modification

Worker: _____ Claim #: _____

Employer: _____

This modification is being provided to accommodate my work restrictions so I may perform my job duties and return to work.

My employer and I will need to agree upon who will own the equipment and note it below. (Typically, a worker would be listed as the owner for any portable items.)

The designated party will own these items when I successfully return to work. Any equipment owned by the employer must remain available to me during my shift.

Maintenance Responsibility:

Safekeeping, proper maintenance and repair of the equipment (beyond the expiration of the manufacturer's warranty, if applicable) are the responsibility of the identified owner.

Return Policy:

I will return any items to L&I if not used by me or if I am not able to successfully return to work. I will contact L&I and make arrangements to return the equipment to the nearest service location.

If the employer paid for any cost of the modification, or the equipment is affixed to the work site, the employer may retain the equipment, regardless of the outcome of the modification or return to work.

I understand the agreement above and I am willing to comply with the terms.

Worker Signature

Date

Employer Signature

Date

Inventory

Equipment/model #	Owner (upon successful completion)

**INSTRUCTIONS FOR COMPLETING THE JOB MODIFICATION ASSISTANCE APPLICATION FORM
(F245-346-000)**

NOTE: SUBMIT A SEPARATE APPLICATION FOR EACH VENDOR.

- 1) **DATE OF INJURY:** Record the date of injury.
- 2) **CLAIM NUMBER:** For the injured worker on whose behalf the application is being submitted.
- 3) **INJURED WORKER'S NAME:** Injured worker's full name.
- 4) **ACCEPTED DIAGNOSIS:** Record the accepted industrial condition(s).
- 5) **VOCATIONAL COUNSELOR/JOB MODIFICATION CONSULTANT:** Record the name of the individual submitting the application (must be vocational counselor, job modification consultant, or employer that has been trained in completing the applications.) May not be submitted by the worker.
 - a) **FIRM NAME:** Record the firm that the vocational counselor/job modification consultant represents.
 - b) **PROVIDER NO.:** Record the vocational counselor/job modification consultant's provider number.
 - c) **ADDRESS:** Record the vocational counselor/job modification consultant's address, phone, and fax number.
- 6) **JOB TITLE:** Record the actual or anticipated job title for which the application is being submitted.
- 7) **EMPLOYER NAME:** Record the employer's name and telephone number for the job title listed.
- 8) **DESCRIPTION OF WORK RESTRICTIONS:** List the restrictions or limitations in physical capacities that relate to the requested modification.
- 9) **DESCRIPTION OF JOB MODIFICATION:** Briefly list the equipment being requested and the reason for the request.
- 10) **ITEMIZATION OF COSTS:**
 - a) **EQUIPMENT:** Record the cost of equipment being requested.
 - b) **TOOLS:** Record the cost of any tools being requested.
 - c) **OTHER:** Record the cost of non-equipment, non-tool items, such as training time.
 - d) **ASSEMBLY:** Record the cost of assembly, installation and delivery.
 - e) **TOTAL:** Record total cost of modifications requested for this vendor.
 - f) **EMPLOYER'S PORTION:** Record the amount the employer will pay to the vendor.
 - g) **STATE FUND (SF) OR SELF-INSURED (SIE) PORTION:** Record the amount the SF or SIE is asked to pay.
- 11) **REQUIRED DOCUMENTATION**
 - a) **REPORT:** If the report has been previously submitted, please indicate that it is "on file".
 - b) **BIDS:** Submit two bids for any item over \$2,500.00. The price includes any tax, shipping, delivery, and training charges. If the item is only available from one vendor, please specify that it is a sole source item.
 - c) **OWNERSHIP AGREEMENT:** Submit completed form F245-346-000, page 2.
- 12) **VENDOR:** Enter the vendor's name, address, phone and provider number. Vendors must have a provider number in order to be reimbursed.

Mail completed application form to:
 Department of Labor & Industries
 Claims Section
 PO Box 44291
 Olympia WA 98504-4291



PRE-JOB ACCOMMODATION ASSISTANCE APPLICATION

One vendor per application form		Date of injury	Claim number
Injured worker's name		Accepted diagnosis	
Vocational counselor/pre-job accommodation consultant		Provider number	
Firm's name		Phone number	
Address		Fax number	
City	State	ZIP+4	

Proposed job title	For: <input type="checkbox"/> Retraining site <input type="checkbox"/> Job/Return-to-Work goal
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RESTRICTIONS	DESCRIPTION OF PRE-JOB ACCOMMODATION

ITEMIZATION OF COSTS: Equipment _____ Tools _____ Other _____ Assembly, installation & delivery _____ Tax _____ Total \$ _____	REQUIRED DOCUMENTATION <input type="checkbox"/> Pre-job accommodation narrative or consultation report AND <input type="checkbox"/> Ownership agreement AND <input type="checkbox"/> Attending Doctor's Statement of Medical Necessity AND <input type="checkbox"/> Bids (2 bids if single item over \$2,500)	Labor and Industries (L&I) provider number required for payment. If equipment vendor does not have a L&I provider number - Call: Provider Accounts (360) 902-5140 For payment, submit bill on pink "Statement for Retraining and Job Modification Services" form (F245-030-000). Attach copy of approved application.
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Vendor name	Provider number
Address	
City	State ZIP+4 Phone number

Date	Vocational counselor or consultant signature
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For Dept Use Only	<input type="checkbox"/> Approve	<input type="checkbox"/> Authorization code (0385R) entered on AUTH	<input type="checkbox"/> Authorization amount entered on CLOG	<input type="checkbox"/> Disapprove
Date	Signature authority			

Ownership Agreement for Tools and Equipment Purchased as a Pre-Job Accommodation

Worker _____ Claim #: _____

Return-to-work Goal _____

Required for Return-to-Work (RTW) Goal

- This accommodation is related to my attending health care provider’s requirements for my release to work.
- I will own these items upon my release to work as determined by L&I.

Required for Participation in a Retraining Plan Plan Dates: _____

- This accommodation is related to my attending health care provider’s requirements to participate in my retraining plan.
- These items remain the property of L&I during my retraining plan.
- Permission to use these items is based on cooperative participation in my retraining plan and may be withdrawn at any time while L&I remains the owner.
- I am fully responsible for the custody of the listed items and agree to maintain these items and keep them secure from damage, loss, or theft.
- I will own these items upon my successful completion of the retraining plan as determined by L&I.

Return Policy: If I do not use these items in my RTW goal, if my retraining plan fails, or if my counselor or L&I inform me for any reason that this equipment must be returned, I will do so immediately. I will contact L&I and make arrangements to return the equipment to the nearest service location.

I understand the agreement as shown above and I am willing to comply with the terms.

Worker Signature

Date

Witness Signature

Date

Inventory

Item	Brand/Manufacturer	Model #

INSTRUCTIONS FOR COMPLETING THE PRE-JOB ACCOMMODATION ASSISTANCE APPLICATION FORM (F245-350-000)

This benefit is only available to a worker with a state fund claim or a claim against a defaulting self-insured employer.

NOTE: SUBMIT A SEPARATE APPLICATION FOR EACH VENDOR.

- 1) **DATE OF INJURY:** Record the date of injury.
- 2) **CLAIM NUMBER:** For the injured worker on whose behalf the application is being submitted.
- 3) **INJURED WORKER'S NAME:** Injured worker's full name.
- 4) **ACCEPTED DIAGNOSIS:** Record the accepted industrial condition(s).
- 5) **VOCATIONAL COUNSELOR/ CONSULTANT:** Record the name of the individual submitting the application (must be vocational counselor, pre-job accommodation consultant, or employer that has been trained in completing the applications.) May not be submitted by the worker.
 - a) **FIRM NAME:** Record the firm that the vocational counselor/consultant represents.
 - b) **PROVIDER NO.:** Record the vocational counselor/consultant's provider number.
 - c) **ADDRESS:** Record the vocational counselor/consultant's address, phone, and fax number.
- 6) **PROPOSED JOB TITLE:** Record the actual or anticipated job title for which the application is being submitted.
- 7) **PURPOSE OF ACCOMMODATION:** Specify if the accommodation is needed for the retraining site or for the RTW goal.
- 8) **DESCRIPTION OF RESTRICTIONS:** List the restrictions or limitations in physical capacities that relate to the requested accommodation.
- 9) **DESCRIPTION OF PRE-JOB ACCOMMODATION:** Briefly list the equipment being requested and the reason for the request.
- 10) **ITEMIZATION OF COSTS:**
 - a) **EQUIPMENT:** Record the cost of equipment being requested.
 - b) **TOOLS:** Record the cost of any tools being requested.
 - c) **OTHER:** Record the cost of non-equipment, non-tool items, such as training time.
 - d) **ASSEMBLY:** Record the cost of assembly, installation and delivery.
 - e) **TOTAL:** Record total cost of accommodation requested for this vendor.
- 11) **REQUIRED DOCUMENTATION**
 - a) **REPORT:** If the report has been previously submitted, please indicate that it is "on file".
 - b) **BIDS:** Submit two bids for any single item over \$2,500.00. The price includes any tax, shipping, delivery, and training charges. If the item is only available from one vendor, please specify that it is a sole source item.
 - c) **OWNERSHIP AGREEMENT:** Submit completed form F245-350-000, page 2.
 - d) **ATTENDING DOCTOR'S STATEMENT OF MEDICAL NECESSITY:** Include verification from the attending physician that the accommodations are medically necessary due to the effects of the accepted industrial condition.
- 12) **VENDOR:** Enter the vendor's name, address, phone and provider number. Vendors must have a provider number in order to be reimbursed.