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

STATEMENT FOR CRIME VICTIM MENTAL HEALTH SERVICES

Claim Number

V -

Claimant's full name Last	First	Middle	Social Security Number (for ID only)	Date of Injury
Address			Date of Birth	
City	State	ZIP	**BE SURE TO INCLUDE YOUR PROVIDER NUMBER AND YOUR PATIENT'S CLAIM NUMBER OR YOUR BILL MAY BE DENIED.**	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD Diagnosis Codes).
Designate left or right when applicable.

1.

2.

3.

4.

5.

ENTER ONLY ONE ITEM PER LINE Date of Service	POS	Procedure Code	Mod Code	Describe services provided	If mental health patient is not victim, give name and the relationship to victim.	Charges $	Unit	To Date of Service
1.								
2.								
3.								
4.								
5.								
6.								
7.								

The submission of this bill certifies that the material furnished, service(s) provided, expense incurred, or any 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.	Provider of Service Name	Individual Provider No,/NPI	Total Charge
	Group, Clinic, Center or Facility Name	Group Provider No./NPI	Phone Number
	Address		Your Patient's Account Number
Signature	City	State / ZIP	
Bill date	Federal Tax ID Number	☐ EIN ☐ SSN	
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

RESET

Instructions for Completing Crime Victims Mental Health Services Billing Form

Crime Victims is a secondary insurer. Submit bills to public or private insurance **first**. *You* **must** *attach Primary EOB to your bill.*

Worker Information

Claim Number	Enter claimant's crime victim claim number.
Claimant's Name	Write the claimant's last name, first name and middle initial format.
Social Security Number	Enter claimant's social security number. Used to verify claim number only.
Date Of Injury	The date of injury.
Address	Enter claimant's current address.
Date Of Birth	Enter claimant's date of birth.
Diagnosis	Enter ICD code number and the narrative diagnosis for all conditions treated.

Itemization of Services and Charges

Date Of Service	Enter the month, day and year of service. (e.g., January 04, 2002 = 010402). When billing for more than one date of service, only consecutive days may be billed on the same line. If dates of service are not consecutive, list each date on a separate line.
Place Of Service	Place of Service codes are printed below. Enter appropriate code in space provided.
Procedure Code	Enter the procedure code for the service performed or item provided. Enter only one code per line.
Code Modifier	Modifier code if applicable.
Describe Services Provided	Enter brief description of services provided.
Relationship To Victim	Enter patient's name and relationship to claimant.
Charges	Enter your usual and customary fee for the procedure billed on this line. Do **NOT** bill negative charges.
Unit	Enter the total number of times a procedure is provided per line.
Total Charges	Total of all charges.
Provider Of Service Name	Enter the provider's name.
Provider Number:	Enter the provider of service provider number.
NPI	Enter the provider's National Provider Identifier (optional for Crime Victims Compensation Program).
Provider's Address And Phone Number	Enter provider's physical address.
Total Charge	Total of all charges.
Signature	Signature may be that of the provider or the person preparing the bill. Regardless of who signs the bill, the provider submitting the bill is responsible for its accuracy. If the bill is prepared by computer, the signature may be left blank.
Bill Date	The date your billing was prepared.
Federal Tax I.D. Number	Required. If the provider account number is incorrect this information helps identify the correct provider.
Patient's Account No	The number you use to identify your patient's account. This is for your convenience only.
Amount Paid By Primary Insurance:	The Crime Victims Compensation Program is a secondary insurer, public and private insurance must be billed first. Enter amount paid by public or private insurance.
Name Of Primary Insurance	Enter the name of the public or private insurance making payments on behalf of the claimant.

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