



Instructions

- Complete all applicable portions of this fee bill and mail to the appropriate party, either BWC or the MCO.
- Mail all documentation to the local customer service office.
- For instructions on how to complete this invoice, refer to the BWC's *Billing and Reimbursement Manual*.

1. Bill type (Please check one)

- (K) Dental
- (N) Nursing
- (P) Practitioner
- (R) Vocational rehabilitation
- (V) Other vendor

2. Claim number	3. Injured worker Social Security number	4. Date of injury
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5. Injured worker's name (last, first and middle initial)	6. Injured worker's address (street or P.O. Box, city, state and ZIP code)
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7. Referring physician provider number	8. Referring physician name	9. Prior authorization number (if applicable)
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10. Patient account number (15 max)	11. Provider number	12. Provider name
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13. Check here if total payment is to be made to injured worker <input type="checkbox"/>	14. Group payee number (if different from provider number)
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15. Service date	16. Place of service	17. Procedure code CPT/HCPCS	18. Modification code	19. Diagnostic code ICD-9-CM	20. Description of service	21. Charges	22. Units of service	23. Tooth No.
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I hereby certify the information contained on this form is true and correct to the best of my knowledge and belief.	26. Total charge
24. _____ Provider signature	25. _____ Date

27. Remarks	28. Payee name, address, city, state, ZIP code and telephone number (print, stamp or type)
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