Bureau of Workers' Compensation

Service Invoice (C-19)

Instructions

- Complete all applicable portions of this fee bill and mail to the appropriate party, either BWC or the managed care organization.
- Mail all documentation to the local customer service office.
- For instructions on how to complete this invoice, refer to 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

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)

7. Referring physician provider number	8. Referring physician name	9. Prior authorization number (if applicable)

10. Patient account number (15 max)	11. Provider number	12. Provider name

13. Check here if total payment is to be made to injured worker ☐	14. Group payee number (if different from provider number)

15. Service date	16. Place of service	17. Procedure code CPT/HCPCS	18. Modification code	19. Diagnostic code ICD-CM	20. Description of service	21. Charges	22. Units of service	23. Tooth no.

I hereby certify the information contained on this form is true and correct to the best of my knowledge and belief.

24. _____ Provider signature

25. _____ Date

26. Total charge

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

I certify the information on this form is true and correct. I understand that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.