STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

Send Completed Form To:
Zurich Insurance
PO Box 66941
Chicago, IL 60666-0941
FAX: 847-240-8172

Service Invoice

1. Claimant name (Last, First, Middle)	2. Claimant address (Street or P.O. Box, City, State, Zip)	
3. Social Security Number – last four digits	4. Date of injury/date of last exposure	5. Claim number

6. Diagnosis Code (ICD-9-CM)	Description
(1)	
(2)	
(3)	

7. Check this block if emergency ☐	8. Provide account number	9. Provider FEIN number
10. Check this block if payment is to be made to the claimant ☐	11. Payee name and address	

12. Service Date	13. Procedure Code	14. Mod Code	15. Description	16. Charges	17. Units	18. P.O.S.	19. Dental Tooth No.

20. As provided by statute, this is to certify that the services were rendered as outlined above and that no other or additional charge for such treatment, appliance, or services has been or will be made against any person, firm, or corporation.	21. Total Charge	22. Amount Paid	23. Balance Due
Provider or Claimant Signature Date			

24. Provider Name/Address	25. Remarks
26. Provider Phone Number	27. Provider NPI
	28. Provider UPIN

Instructions for Completing the Service Invoice

Complete all information requested unless otherwise notes. **TYPE OR PRINT LEGIBLY.**

1. CLAIMANT NAME: Enter the Claimant's last name, first name, and middle initial with the spelling exactly as it appears on his/her compensability approval letter or social security card.
2. CLAIMANT ADDRESS: Enter the Claimant's full mailing address including street number, post office box, or rural route number, city, state, and zip code.
3. CLAIMANT SOCIAL SECURITY NUMBER: Enter the last four digits of the social security number of the Claimant.
4. DATE OF INJURY/ DATE OF LAST EXPOSURE: In an injury claim, this is the date the Claimant was injured. In an Occupational Pneumoconiosis or disease claim, this is the date of last exposure.
5. CLAIM NUMBER: The number assigned to the claim by Zurich Insurance. This number is found on the Claimant's compensability approval letter.
6. DIAGNOSIS CODE/DESCRIPTION: Using the appropriate ICD-9-CM numeric code, list the Claimant's primary diagnosis followed by the written description of the condition. The ICD-9-CM numeric code is listed on the Zurich ID card which is issued to the Claimant. Prefix codes "E" and "M" are not acceptable.
7. IF EMERGENCY, CHECK THE BLOCK: Check this block if services were rendered on an emergency basis only.
8. PROVIDER ACCOUNT NUMBER: Enter the account number assigned to the Claimant by the provider's office. Information listed in this field will be entered and reported on the provider's Remittance Advice.
9. PROVIDER NUMBER: Enter the Federal Employer Identification Number (FEIN). In addition, some providers may need to enter a two-digit office location code, if notified by Zurich Insurance.
10. CHECK THIS BLOCK IF PAYMENT IS TO BE MADE TO THE CLAIMANT: If payment is to be made to the Claimant, check this block.
11. PAYEE NAME AND ADDRESS: If block 17 is completed, list the payee's name and address.
12. SERVICE DATE: Enter the date on which the service was provided in MM/DD/YY format, such as 06/09/99 for June 9, 1999.
13. PROCEDURE CODE: Enter the appropriate CPT4, HCPCS, or ADA procedure code for the service billed.
14. MODIFIER CODE: Enter the appropriate modifier when required.
15. DESCRIPTION: Provide a narrative description of the procedure listed in Block 20. Abbreviations and short descriptions are acceptable.
16. CHARGES: Enter the total charge for each procedure code used.
17. UNITS: Enter the number of units for the procedure or service listed in Block 20.
18. PLACE OF SERVICE (POS) CODE: Enter the appropriate place of service code from the list provided.

Code	Description	Code	Description	Code	Description
11	Office	33	Custodial Care Facility	60	Mass Immunization Center
12	Home	34	Hospice	61	Comprehensive Inpatient Rehab Center
21	Hospital (Inpatient)	41	Ambulance (Land)	62	Comprehensive Outpatient Rehab Facility
22	Hospital (Outpatient)	42	Ambulance (Air and Water)	65	End Stage Renal Treatment Facility
23	Hospital (Emergency Dept.)	51	Psychiatric Facility (Inpatient)	71	State of Local Public Health Clinic
24	Ambulatory Surgical Ctr. (ASC)	52	Psychiatric Facility (Outpatient)	72	Rural Health Clinic
25	Birthing Center	53	Community Mental Health Ctr.	81	Independent Lab
26	Military Treatment Facility	54	Intermediate Care Facility	99	Other Unlisted Facility
31	Skilled Nursing Facility	55	Residential Substance Abuse Facility		
32	Nursing Facility	56	Psychiatric Residential Treatment Center		

19. DENTAL TOOTH NUMBER: Dental only-list tooth number.
20. PROVIDER OR CLAIMANT SIGNATURE: The invoice must be signed by the provider or a legally responsible designee or the Claimant. Signature stamps are acceptable.
21. TOTAL CHARGE: Total charge for services billed to Zurich Insurance.
22. AMOUNT PAID: If someone other payment has been paid, list the amount. In Block 33, list the name, address, city, state, zip code and phone number of any other payee.
23. BALANCE DUE: Total amount due.
24. PROVIDER NAME AND ADDRESS: Enter the name and address which corresponds to the provider number listed in Block 15. DO NOT list the payee's name and address if it differs from the servicing provider.
25. REMARKS: Use this block to briefly explain the necessity of any unusual services or fees.
26. PROVIDER PHONE NUMBER: List the phone number where you can be contacted.
27. PROVIDER NPI: List the assigned National Provider Identifier.
28. PROVIDER UPIN: List the assigned Unique Physician Identifier Number.