Service Invoice

Return completed form to:

BrickStreet Insurance
P.O. Box 3151
Charleston, WV 25332-3151

COMPLETE ALL INFORMATION REQUESTED UNLESS OTHERWISE NOTED. TYPE OR PRINT LEGIBLY

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

6. Diagnosis Code(s)	Description
(1)	
(2)	
(3)	

7. Authorization number	8. Check this block if emergency ☐	9. Provider account number	10. Provider FEIN number
11. Check this block if payment is to be made to the claimant ☐	12. Payee name and address		

13. Service Date	14. Procedure Code	15. Mod Code	16. Description	17. Charges	18. Units	19. P.O.S.	20. Dental Tooth No.

21. 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 service has been or will be made against any person, firm, or corporation.	22. Total Charge	23. Amount Paid	24. Balance Due
Provider or Claimant Signature Date			

25. Provider Name/Address	26. Remarks
	28. Provider NPI
27. Provider Phone Number	29. Provider UPIN

Instructions for Completing the Service Invoice (BI-400)

Complete all information requested unless otherwise noted. **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 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 BrickStreet Insurance. This number is found on the Claimant's compensability approval letter.
6. **DIAGNOSIS CODE/DESCRIPTION:** List the claimant's primary diagnosis code and written description followed by any secondary diagnosis codes/descriptions, if appropriate. Note, the primary diagnosis code is listed on the claimant's BrickStreet ID card.
7. **AUTHORIZATION NUMBER:** Services that require prior authorization must have an authorization number. This number appears on the letter sent to the Claimant granting authorization for the service or procedure. There is no number for an Occupational Pneumoconiosis examination.
8. **IF EMERGENCY, CHECK THIS BLOCK:** Check this block if services were rendered on an emergency basis only.
9. **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.
10. **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 BrickStreet.
11. **CHECK THIS BLOCK IF PAYMENT IS TO BE MADE TO THE CLAIMANT:** If payment is to be made to the Claimant, check this block.
12. **PAYEE NAME AND ADDRESS:** If *Block 11* is completed, list the payee's name and address.
13. **SERVICE DATE:** Enter the date on which the service was provided in MM/DD/YY format, such as 01/01/17 for January 1, 2017.
14. **PROCEDURE CODE:** Enter the appropriate CPT4, HCPCS or ADA procedure code for the service billed.
15. **MODIFIER CODE:** Enter the appropriate modifier when required.
16. **DESCRIPTION:** Provide a narrative description of the procedure listed in *Block 14*. Abbreviations and short descriptions are acceptable.
17. **CHARGES:** Enter the total charge for each procedure code used.
18. **UNITS:** Enter the number of units for the procedure or service listed in *Block 16*.
19. **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 or Local Public Health Clinic
24	Ambulatory Surgical Center (ASC)	52	Psychiatric Facility (Outpatient)	72	Rural Health Clinic
25	Birthing Center	53	Community Mental Health Center	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		

20. **DENTAL TOOTH NUMBER:** Dental only-list tooth number.
21. **PROVIDER OR CLAIMANT SIGNATURE:** The invoice must be signed by the provider or a legally responsible designee or the Claimant. Signature stamps are acceptable.

    DATE: Enter the date the invoice was signed and submitted to BrickStreet.
22. **TOTAL CHARGE:** Total charge for services billed to BrickStreet.
23. **AMOUNT PAID:** If some other payment has been paid, list the amount.
24. **BALANCE DUE:** Total amount due.
25. **PROVIDER NAME AND ADDRESS:** Enter the name and address which corresponds to the provider number listed in *Block 10*. DO NOT list the payee's name and address if it differs from the servicing provider.
26. **REMARKS:** Use this block to briefly explain the necessity of any unusual services or fees.
27. **PROVIDER PHONE NUMBER:** List the phone number where you can be contacted.
28. **PROVIDER NPI:** List the assigned National Provider Identifier.
29. **PROVIDER UPIN:** List the assigned Unique Physician Identifier Number.