CLAIM FOR HOME NURSING SERVICES

Click to clear form

WYOMING DEPARTMENT OF WORKFORCE SERVICES

DIVISION OF WORKERS' COMPENSATION
307-777-7441

PLEASE PRINT OR TYPE IN BLACK INK

Injured Worker Information

CASE # ______________________

SSN #________________ ________________
Date of Birth

DATE OF INJURY________________________

NAME ________________________

ADDRESS ________________________

CITY ______________ STATE ______ ZIP ______

Provider Information

FEDERAL TAX ID # OR SOCIAL SECURITY # ______________________
Required for payment

NAME ________________________

ADDRESS ________________________

CITY ______________ STATE ______ ZIP ______

PHONE # ( ) ________ – ____________

RATE PER HOUR ________________________

Service Dates FROM:________________ Service Dates TO:________________

DAY	ACTUAL TIME		TOTAL HOURS	TOTAL CHARGES	DAY	ACTUAL TIME		TOTAL HOURS	TOTAL CHARGES
	FROM	TO				FROM	TO		
	☐ AM ☐ PM	☐ AM ☐ PM				☐ AM ☐ PM	☐ AM ☐ PM		
	☐ AM ☐ PM	☐ AM ☐ PM				☐ AM ☐ PM	☐ AM ☐ PM		
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	☐ AM ☐ PM	☐ AM ☐ PM			**TOTAL**				

I hereby certify under penalty of perjury, that all times shown on the above bill are accurate and actual hours worked by me personally.

________________________ ____________
Provider Signature (required) **Date**

INSTRUCTIONS FOR FILING: **Submit billing no later than the 30th of each month for prior month's services or CLAIM MAY BE DENIED**

MAIL ORIGINAL TO: **Division of Workers' Compensation**
PO Box 20070
Cheyenne, WY 82003-7001

WSCD-6A (Rev 08/11)