STATE OF WASHINGTON

DEPARTMENT OF LABOR AND INDUSTRIES

INSURANCE SERVICES — HEALTH SERVICES ANALYSIS

PO Box 44261 • Olympia Washington 98504-4261

Dear Provider,

Thank you for your interest in treating or providing services for Washington's injured workers and crime victims. This application is for providers who are:

- In-state, non-primary care physicians, such as Physical, Occupational and Massage Therapists, etc.
- Facilities such as DME Supplier, Hospital, Pharmacy, Laboratory, Nursing Home, etc.
- Vendors such as Transportation, Vocational Rehabilitation, Training, etc.
- Out-of-state providers treating Washington state injured workers and crime victims.

To apply for a provider account, submit:

☐ A completed Provider Account Application. If you are a member of a group, each provider must submit a separate application to bill for services.

☐ A signed copy of the Provider Agreement page (page 7).

☐ A completed Statewide Payee Registration form (two pages).

Note:

- Please complete Steps 1 through 5.
- Submit a copy with each provider's application.
- L&I cannot accept any forms with crossed or whitened out information.
- The legal name in Step 2 and 5 must match the legal name associated with the Tax ID.
- The address on Step 2 of the Statewide Payee Registration must match the payment address on the Provider Account Application.
- L&I cannot accept a federal W-9 in substitute for the Statewide Payee Registration form.

☐ A copy of your license or certification as required by your state health regulations.

Once your application is processed, you will receive a letter containing your L&I provider account number. This is the number that you will use to bill the department.

L&I offers electronic billing. For more information, visit: www.Lni.wa.gov/ElectronicBilling.

If you have any questions, please email: PACMail@Lni.wa.gov.

Thank you,

Provider Accounts and Credentialing Unit

Application Instructions

Complete this application by printing clearly. Use dark ink.

Individual providers must complete Sections A, B, and D.

Facilities must complete Sections A, C, and D.

A. Business Information

1. Credentialing Contact Information:
   - This is the person L&I can contact if there are credentialing questions or if additional documentation is needed for this application (i.e. credentialer, office manager, etc.).
2. Business Information:
   - Tax Payer Identification Number — Employer Identification Number (EIN) or Social Security Number (SSN) used when billing L&I. Provide ***only one.***
   - Practice Name — the business name of the location where services are provided.
   - Organization NPI — the organization's NPI number that will be used for billing purposes. This is a Type 2 NPI number.
   - L&I Group Number — this is for those who are a member of a previously established L&I group number.
3. Physical Location Address:
   - Location Address — L&I **does not** accept a P.O. Box as a physical address of the business.
   - Phone Number — the number injured workers can call to schedule services.
   - Fax Number — the number injured workers can use to send documentation.
4. Payment Address:
   - Payment Address — where L&I will send the:
     - Explanation of Benefits (EOBs) and Remittance Advices (RAs).
     - Payments will be sent to this address if a check in the US mail is selected. If there is an issue with the direct deposit, payments will be sent to this address instead.
     - This address must match the payment address on Step 2 of the Statewide Payee Registration form.
   - Phone Number — the number L&I can call with billing questions.
   - Fax Number — the number L&I can use to fax billing documentation.
5. Correspondence Address:
   - Correspondence Address — this is where L&I will send all general mail.
   - Correspondence Phone Number — the number L&I can call to contact the provider/office staff.
   - Correspondence Fax Number — the number L&I can use to fax documentation to provider/office staff.

B. Individual License & Certification Information
(If you're applying for a facility only, you may skip this section.)

1. Individual Provider Type — mark only one box next to the applicant's provider type as indicated on his/her license or certification. A separate application is required for each provider who renders services.
    - Provider's Name — last, first, middle initial.
    - Gender.
    - Provider's License/DEA/Certification — enter the number, expiration date, issue date, and state where issued for provider's professional license, DEA, and/or certification. Attach a copy of provider's current license/DEA/certification to the application.
    - Individual NPI — enter provider's individual NPI number that will be used for billing purposes. This is a Type 1 NPI number.
    - Language(s) — fluently spoken by the provider.
    - Provider Specialty — type of services provided.
    - NCCP # — for PACs only.
    - Sponsoring or Supervising Physician's Name — for PACs only — physician assistant's supervising physician's name.
    - Active L&I Provider Number for the sponsoring or supervising physician — both providers must have an active account under the same tax identification number (TIN).
2. Find-A-Doc — select "Yes" or "No." If left blank, the provider will be listed on the website.

C. Facility License & Certification Information
(If you're applying for an individual provider, you may skip this section.)

1. Facility Type — mark only **one** box next to the type of facility or business.
    - Facility Name — the business name as it appears on license/certification/accreditation.
    - Facility License/DEA/Certification — enter the number, expiration date, issue date, state where issued, and the status of the facility license, DEA, accreditation, certification and/or business license. **Attach** a copy of the current license/DEA/accreditation/ certification/business license to the application.
    - Organization NPI — the organization's NPI number that will be used for billing purposes. This a Type 2 NPI number.
    - NCPDP/NABP Number (Pharmacy Only) — enter NCPDP/NABP Number.
    - CLIA (Laboratory Only) — enter CLIA Number and attach a copy of CLIA. L&I can't accept a waived CLIA.
    - Other Specialized Information — optional — any additional specialized information.

D. Provider Agreement

Please review and sign. If the Provider Agreement has been altered or is missing a signature, the application will be considered incomplete and returned unprocessed.

E. Statewide Payee Registration Form

- Please complete Steps 1 through 5.
- Submit a copy for each provider's application.
- L&I can't accept any forms with crossed or whitened out information.
- The legal name in Step 2 and Step 5 must match the legal name associated with the Tax ID.
- The address on Step 2 of the Statewide Payee Registration must match the payment address on the Provider Account Application.
- L&I can't accept a federal W-9 in substitute for the Statewide Payee Registration form.

Note: Refer to the separate instructions for completing the Statewide Payee Registration form.

Washington State Department of Labor & Industries

Provider Account Application

Mail or fax completed applications to:
Provider Accounts and Credentialing
PO Box 44261
Olympia WA 98504-4261

Fax: 360-902-4484

Please print clearly and use dark ink.

Questions? Email: PacMail@Lni.wa.gov

For L&I Use Only — Provider Account Number

A. Business Information

1. Contact Information — who L&I can contact with questions about this application

Name	Email Address
Phone Number	Fax Number

2. Business Information

Tax Payer Identification Number (EIN or SSN — *only one*)	Practice Name (DBA)
Organization NPI	L&I Group Number

3. Physical Location Address — where services are provided

Street Address		
City	State	Zip Code
Phone Number	Fax Number	

4. Payment Address — where you want your checks and remittance advices to go

☐ Same as Location Address

Address		
City	State	Zip Code
Phone Number	Fax Number	

5. Correspondence Address — where you want general L&I mail to go

☐ Same as Location Address ☐ Same as Payment Address

Address		
City	State	Zip Code
Phone Number	Fax Number	

Name of Applicant (Last, First, MI) or Facility

B. Individual License and Certification Information

- A separate application is needed for each provider.
- All providers must include a current copy of the provider's state license.
- Prescribing provider — include a copy of the provider's DEA Number.
- Physical Medicine and Rehabilitation Physicians — include copies of your certification.
- RNFA nurses — include copies of your privilege letter for each facility you work for.
- Interpreters — include the Provider Credential for Interpretative Services Form (F245-055-000) and a copy of your certification.

1. Individual Provider Type — mark only one box

☐ Audiologist	☐ Occupational Therapist
☐ Chiropractor	☐ Optician
☐ COHE Administrator	☐ Optometrist
☐ Dentist	☐ Osteopathic Physician
☐ Dietitian	☐ Physical Therapist
☐ East Asian Acupuncture	☐ Physician
☐ Health Service Coordinator	☐ Physician Assistant (Certified)
☐ Hearing Aid Fitter/Dispenser	☐ Podiatrist
☐ Interpreter	☐ Prosthetic/Orthotics
☐ Massage Therapist	☐ Psychologist
☐ Naturopath	☐ Respiratory Therapist
☐ Nurse	☐ Speech/Language Pathologist

Provider Name (Last, First, Middle Initial)			Gender
License Number	License Issued Date	License Expiration Date	State Where Issued
DEA Number	DEA Issued Date	DEA Expiration Date	State Where Issued
Certification	Certification Issued Date	Certification Expiration Date	Certification Status
Individual NPI		Language(s) Fluently Spoken by Provider	
Provider Specialty		NCCPA Number (PACs Only)	
Sponsoring/Supervising Physician's Name (PACs Only)		L&I # for Sponsoring/Supervising Physician (PACs Only)	

2. Find-A-Doc (FAD) Websites

Do you want your contact information included on the Find-A-Doc websites so workers or crime victims may locate your business for services in their area? If left blank, the provider will be listed on the websites.

Workers (State Fund)
☐ Yes ☐ No
www.Lni.wa.gov/FindADoc

Crime Victims
☐ Yes ☐ No
www.Lni.wa.gov/ClaimsIns/CrimeVictims/FindaDoc/

Name of Applicant (Last, First, MI) or Facility

C. Facility License and Certification Information

- Ambulatory Surgery Centers — include copies of your state license, Medicare certification, or accreditation by JCAHO, AAAHC, or AAAASF.
- Laboratories — include copies of your Clinical Laboratory Improvement Amendments (CLIA).
- Pain Clinics — include copies of your Commission on Accreditation of Rehabilitation Facilities (CARF).
- Pharmacies — include copies of your DEA permit, pharmacy license, and NCPDP or NABP number.
- Schools — include your accreditation and business license.

1. Facility Type — mark only one box

☐ Ambulance	☐ Nursing Home — Adult Family Home
☐ Ambulatory Surgery Center	☐ Nursing Home — Boarding Home
☐ Bookstore	☐ Nursing Home — Head Injury
☐ Daycare	☐ Nursing Home — Residential Treatment
☐ Durable Medical Equipment (DME) Supplier	☐ Nursing Home — Skilled Nursing Facility
☐ Drug and Alcohol Treatment Facility	☐ On The Job Training
☐ Emergency Room — Free Standing	☐ Pain Clinic
☐ Home Health Agency — Head Injury	☐ Pharmacy
☐ Home Health Agency — Home Care/Hospice	☐ Pharmacy — Infusion Therapy
☐ Home Health Agency — Infusion Therapy	☐ Radiology — Technical Component Only
☐ Home Health Agency — Infusion Therapy and Home Care	☐ Rehab Training Facility
☐ Home Modification	☐ Rehab Training Supplier
☐ Hospital — Full Care	☐ School
☐ Hospital — Psychiatric	☐ Tape Intermediary
☐ Hospital — Outpatient Only	☐ Tool Distribution
☐ Independent Diagnostic Testing	☐ Transportation — Airline
☐ Investigative Services	☐ Transportation — Bus
☐ Job Modification/Pre-Job Modification Consultant	☐ Transportation — Ferry
☐ Job Modification/Pre-Job Modification Supplier	☐ Transportation — Taxi
☐ Laboratory	☐ Transportation — Toll Bridge
☐ Lodging	☐ Vehicle Modification
☐ Nursing Home	☐ Vocational Testing

Facility Name			
Facility License Number	License Issued Date	License Expiration Date	State Where Issued
DEA Number	DEA Issued Date	DEA Expiration Date	State Where Issued
Accreditation Number	Accreditation Issued Date	Accreditation Expiration Date	Accreditation Status
Certification Number	Certification Issued Date	Certification Expiration Date	Certification Status
Business License Number	License Issued Date	License Expiration Date	State Where Issued
Organization NPI	NCPDP/NAPB (*Pharmacies Only*)	CLIA (*Laboratories Only*)	
Other Specialized Information			

Name of Applicant (Last, First, MI) or Facility

D. Provider Agreement

I have read, understand, and agree to the following:

Fitness to Serve:

- I agree to meet and maintain all licensing and/or certification requirements.
- I certify that I am currently in good standing with my mental health.
- I certify that I do not have impairment due to chemical or substance abuse or dependency.
- I certify that I do not have a history of loss of license, certification, or registration.
- I certify that I do not have a loss or limitation of privileges.
- I certify that I do not have felony convictions.

Account Maintenance:

- I certify that the information in this application is correct.
- I agree to notify the Department of Labor and Industries (L&I) immediately in writing of any changes to the information in this application including but not limited not: provider status (e.g. licensing, certification, registration, disciplinary action, limitation of privileges); federal tax information changes; and location, payment, or correspondence addresses.
- I under that L&I reserves the right to deny, revoke, suspend, or place conditions on my authorization to treat worker or crime victims in accordance with Washington State law.

Billing:

- I agree to accept the department's or the self-insurer's payment as sole and complete remuneration for services provided to the worker in accordance with WAC 296-20-020.
- I understand that Crime Victims compensation is secondary to any public or private insurance the victim may have.
- I agree to bill the department or self-insurer according to policies in the Medical Aid Rules and Fee Schedule (MARFS).
- I agree to bill the department or self-insurer my usual and customary fee.
- I certify that all services provided are related to the industrial injury, occupational disease, or injury covered by the Crime Victims Act.
- I agree that I will not bill the worker or crime victim for the difference between the billed amount and the amount paid.
- I agree that I will not bill the worker or crime victim the difference between my customary fee and the department's fee schedule.

Provider's Statement of Agreement:

I (provider/business/company representative), _____

agree to abide by the terms of this agreement and by all applicable federal and Washington State statues, rules, and policies. I have enclosed with my application all required supporting information necessary to establish a provider account, including applicable copies of my current licenses and certifications, and a completed Statewide Payee Registration for the state of Washington Department of Labor and Industries.

Signature	Title	Date

Name of Applicant (Last, First, MI) or Facility

Statewide Payee Registration for Washington State Department of Labor and Industries

STEP 1: Is this a NEW registration or CHANGE to an existing registration (check one)?

☐ **NEW REGISTRATION** — complete the **ENTIRE** form (STEPS 1 — 6)

☐ **EXISTING REGISTRATION** – complete the **ENTIRE** form (STEPS 1 – 6) and check below what is updated:

☐ Adding a New Provider ☐ Name/DBA ☐ Address ☐ Contact Information ☐ Email ☐ Payment Options
☐ Direct Deposit ☐ Additional Information

If you know your Statewide Vendor Number, enter it here: SWV _____

STEP 2: Enter information about the payee and contact person

Legal Name (as shown on your income tax return) _____

SSN _____ **OR** **EIN** _____

Business Name, if different from Legal Name above – e.g. Doing Business As (DBA) Name _____

Contact Person _____

Payment Address (where payments will be sent) _____

Contact Telephone Number _____

City, State, and Zip Code _____

Contact Fax Number _____

Email to receive Statewide Vendor Number and payment notifications _____

For L&I Use Only:

2350 / MIPS / O /
L&I # / System / Ownership / L&I Provider #

Type of Business _____

STEP 3: Select Payment Option:

☐ Direct Deposit to bank (recommended) ☐ Check in US mail (terminates any previous banking information on file)

If direct deposit is checked, complete STEP 4.

STEP 4: For Direct Deposit, complete all fields below and sign

Financial Institution Name – must be a US institution _____

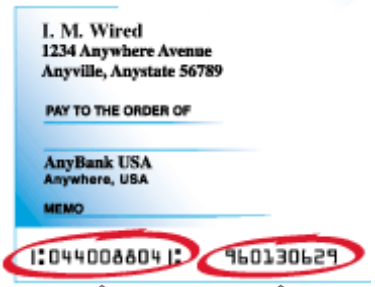
Financial Institution Phone Number _____

Routing Number – see example at right _____

Account Number – see example at right _____

In addition to providing your banking information on this form, you may attach a voided check.

Account Type: ☐ Checking or ☐ Savings (Checking will be used if neither box is marked.)



Authorization for Direct Deposit:

I hereby authorize and request the Consolidated Technology Services (CTS) and the Office of the State Treasurer (OST) to initiate credit entries for payee payments to the account indicated above, and the financial institution named above is authorized to credit such account. I agree to abide by the National Automated Clearing House Association (NACHA) rules with regard to these entries. Pursuant to the NACHA rules, CTS and OST may initiate a reversing entry to recall a duplicate or erroneous entry that they previously initiated. I understand that if a reversal action is required, CTS will notify this office of the error and the reason for the reversal. This authority will continue until such time CTS and OST have had a reasonable opportunity to act upon written request to terminate or change the direct deposit service initiated herein.

Authorized Representative (Please Print) _____ Title _____

SIGNATURE of Authorized Representative _____ Date _____

Continue to STEP 5

STEP 5: REQUIRED – Complete and sign the Request for Taxpayer Identification Number (W-9)

Substitute Form **W-9**	**Request for Taxpayer Identification Number and Certification**	

1. Legal Name (as shown on your income tax return)

2. Business Name, if different from Legal Name above – eg. Doing Business As (DBA) Name

3.Check ONLY ONE box below (see W-9 instructions for additional information)

☐ Individual or Sole Proprietor ☐ LLC filing as a sole proprietor ☐ Partnership	☐ Corporation ☐ S-Corp	☐ LLC filing as Corporation ☐ LLC filing as Partnership ☐ LLC filing as S-Corp	☐ Non Profit Organization ☐ Volunteer ☐ Board /Committee Member	☐ Local Government ☐ State Government ☐ Federal Government (including tribal)	☐ Tax-exempt organization ☐ Trust/Estate

4. For Corporation, S-Corp, Partnership or LLC, check one box below if applicable:

☐ Medical ☐ Attorney/Legal

5. If exempt from backup withholding, check here: ☐ (See instructions for W-9 to determine if you are exempt from backup withholding.)

6. Address (number, street, and apt. or suite no.)

7. City, State, and ZIP code

Department of Labor and Industries
Attn: Provider Credentialing and Compliance
PO Box 44261
Olympia Wa 98504-4261

8. Taxpayer Identification Number (TIN)

Enter your EIN OR SSN in the appropriate box to the right (do not enter both)
For individuals, this is your social security number (SSN).
For other entities, it is your employer identification number (EIN).

NOTE: The EIN or SSN must match the Legal Name as reported to the IRS. For a resident alien, sole proprietor, or disregarded entity, or to find out how to get a Taxpayer Identification Number, see the W9 Instructions. If the account is in more than one name, see the W9 Instructions for guidelines on whose number to enter.

Social security number

			-			-				

Employer identification number

		-							

9. Certification

Under penalty of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. person (including a U.S. resident alien).

(For additional information about the W-9 see the W-9 Instructions.)

SIGNATURE of U.S. PERSON	Date

STEP 6: Submit to ONE of the following

For Medical Provider

Provider Account Application & Pay Hold Releases:	FAX: *360-902-4484*
Provider Network Application (WPA):	FAX: *360-902-4563*
Crime Victims Compensation:	FAX: *360-902-5333*
Or mail to:	**Provider Credentialing & Compliance** **PO Box 44261** **Olympia, WA 98504-4261**

For questions contact Provider Credentialing: 360-902-5140 and select option 4

Instructions for the Statewide Payee Registration Form

The term 'payee' refers to an individual or business that received payments from the State of Washington. This form is intended to be used for payees to register with the State of Washington, indicate how they would like to receive payments, and change their registration information.

For prompt payment, it is important that we receive complete and accurate information. ***We must return any form that is not complete, so please be sure to read and follow these instructions carefully***.

Step 1: Is this a new registration or a change to an existing registration?

Select ***NEW REGISTRATION*** if:

- You have never completed the Statewide Payee Registration Form.
- You are changing the legal name of a payee already registered.
- You are changing the EIN (Employer Identification Number) or SSN (Social Security Number) of a payee already registered
- You are changing the reporting type (sole proprietor, corporation, etc) on an existing registration.

Select ***CHANGE TO EXISTING REGISTRATION*** for all other changes to an existing registration, and check the items that have changed. Be sure to **COMPLETE the ENTIRE form**, even if you are only changing one item. This will help us keep your account up to date and accurate. If you know your SWV number, please enter it on the form.

Step 2: Payee & contact information

Legal name of payee – enter the name as it appears on federal tax forms.
Business name – "doing business as" name. Enter only if different from legal name.
Payment address – enter the PO Box or street address where you want information sent to you. If you choose to have checks mailed to you, this is the address where they will be sent.
Email for contact person - enter the email address we should use to communicate with you about your registration and your payments. We will use the email address to:

- Notify you when your account has been set up.
- Notify you when changes you submitted have been made.
- Notify you when your payment has been processed, if you have signed up for direct deposit.

Type of business – enter the primary occupation of the payee.
SSN or EIN – enter the SSN or EIN you use with the IRS for the legal name entered.
Contact person – the person we can contact with questions about your registration.
Contact telephone number – telephone number of the contact person.
Contact fax number – fax number of the contact person.

NOTE: For larger organizations we recommend that you use the email address for a distribution list to ensure that our notifications are received and processed quickly.

Step 3: Payment options

Indicate if you want to receive your payments via Direct Deposit or via US Mail.

Step 4: Direct deposit information

Financial institution name & phone number – enter the name and phone number of the financial institution where you want your funds deposited. This ***must*** be a US institution.
Routing number – this is the 9 digit Bank Identification Number assigned by the American Banking Association. The routing number is the first 9 numbers at the bottom of your check. See example on form. Do not use the routing number from a generic deposit slip – these begin with the number '5.'
Account number – this is your bank account number, and can vary in length. It usually follows the routing number on the check
Account type – select the kind of account your payment will be deposited into. If you do not make a selection, funds will be transferred into the checking account.
Authorization Signature – in order for us to process the Direct Deposit, we need the signature of the person on file with the bank.

Step 5: W-9

The IRS has issued new regulations governing how we report payments and calculate withholding. ***We need this complete, signed W-9 in order to process your registration and verify any changes to it.***
1. Legal name of payee – enter the name as it appears on federal tax forms.
2. Business name – "doing business as" name. Enter only if different from legal name.
3. Check one box for your IRS reporting type – you must check ONLY one box to indicate if you are an individual, corporation, non-profit organization, etc.
4. Check if the business is medical or legal - If you are a corporation, S-corporation, partnership or LLC, and your business is medical or legal, you must check the appropriate box. See the W-9 instructions for more information about reporting types.
5. Select if you are exempt from backup withholding.
6. Address – enter the PO Box or street address where you would like your 1099 mailed.
7. City, State and ZIP
8. Taxpayer Identification Number – enter the Employer Identification Number (EIN) ***OR*** Social Security Number (SSN) you use with the IRS for the legal name entered. DO NOT ENTER BOTH. Enter ONLY the one that you use with the IRS for the legal name.
9. SIGN the W-9

Step 6: Submit to one of the following:

Provider Network Application (WPA)	**FAX:** *360-902-4563*
Non-Network Provider Application	**FAX:** *360-902-4484*
Crime Victims Compensation	**FAX:** *360-902-5333*

Or mail application to: Provider Credentialing & Compliance
PO Box 44261
Olympia, WA 98504-4261

For questions, contact Provider Credentialing at 360-902-5140 and select option 4.