STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
Crime Victims Compensation Program
PO Box 44520 • Olympia, Washington 98504-4520

Dear Provider:

If you choose to become an established provider with us, please complete the enclosed provider application and return it to us at your earliest convenience. Upon registration, you will receive your provider account number and a packet of information related to billing our program for your services. We have published a mental health fee schedule which is available on our website, www.CrimeVictims.Lni.wa.gov. If you have any questions related to our reimbursement rate you may contact our toll free number.

The Crime Victims Compensation Program (CVCP) is currently reimbursing providers a percentage of the billing rates used by the Department of Labor and Industries. Our program is the last payer of benefits. Crime victims must first use any private or public insurance they have before the CVCP can pay.

If you are currently treating a crime victim with an allowed claim and choose not to conduct further business with us, you cannot bill the victim for services you have provided thus far. To be paid for treatment provided to date, you will need to complete the enclosed provider application agreement and submit it along with your bills to the CVCP for payment consideration. We will assign a provider account number for bill processing purposes. After the bills have been processed and you receive your remittance advice, you may contact us to terminate your account.

If at any time you decide not to accept crime victims as patients, please refer them to our toll free number (1-800-762-3716) for a listing of CVC registered providers located in their area.

Sincerely,

The Crime Victims Compensation Program

MASTER LEVEL COUNSELOR
APPLICATION INSTRUCTIONS

NOTICE:
Each applicant must complete an application. A number will be issued to each individual provider.
If additional copies are needed, copy all portions of the application from the internet or call (360) 902-5377.
Photo copies can be made of this application for completion.

SECTION I: TO BE COMPLETED BY ALL PROVIDERS
Enter the Tax Payer Identification Number (EIN or SSN). **The number you will use to report earnings to the IRS - This must match the information on the W-9.**

SECTION II: TO BE COMPLETED BY ALL PROVIDERS

A. Administrative Information

1. Enter the name of the business you wish to submit your bills and have your account set up as, (DBA).
2. Enter the phone number of the business.

2a. Enter the fax number of the business.

3. Enter the billing address as it appears on your bills submitted to Crime Victims Compensation Program and where payments should be mailed.
4. Enter the physical address of the business.
5. Enter the contact person's name – person who can answer questions regarding your bills or your account.
6. Enter the billing phone number where we may call to ask questions regarding your bills or your account.
7. If you will be attached to a group, please provide group number (for billing purposes).

B. Individual or Organization Information – Complete all applicable information

1. Enter the name of the individual or organization providing services to injured workers.
2. Enter the type of service(s) provided.
3. Enter your license, certification or registration number.
4. Enter the date the license, certification or registration was issued (month, day and year). **ATTACH COPY**
5. Enter the date the license, certification or registration will expire (month, day and year).
6. Enter the state where the license, certification or registration was issued.

C. National Provider Identifier (NPI) Information

1. Enter the individual or organization name.
2. If application is for a subpart, enter subpart name.
3. Check one. Type I – individual counselor
   Type II – mental health clinics.
4. Enter the address associated with the NPI number you have provided.
5. Enter the NPI 10-digit identifier.
6. If application is for a subpart, enter the subpart NPI 10-digit identifier.
7. Enter the taxonomy codes of the individual, organization or subpart. If more than six, please list on a separate sheet of paper.

* **Each January the Internal Revenue Service requires us to send a completed Form 1099 MISC reporting payments of $600.00 or more made to a Federal Tax Identification Number (EIN or SSN) during the last calendar year. If you received payments from more than one department program, you may receive more than one Form 1099 Misc.**

Please Do Not Forget To Read and Sign The "Provider Agreement”

Master Level Counselor Provider Account Application

(Please type or print clearly on all sections)

Return To:

Provider Registration
Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

(360) 902-5377 FAX (360) 902-5333
Internet address: **http://www.lni.wa.gov/FormPub**

Please check:

- ❑ New Provider
- ❑ Address Updates for Reactivation of Provider Account
- ❑ Tax ID Change – Effective Date _____ Required

I. TAX REPORTING INFORMATION

Tax Payer Identification Number (EIN or SSN)

THIS NUMBER MUST MATCH THE W-9 FORM YOU SUBMIT

Unless otherwise notified, your claims related correspondence will go to your business (physical) address.

❑ **Please check if you would like all mail to go to the billing address.**

II. ACCOUNT AND BILLING INFORMATION

A. Administrative Information

1. Business name (as you wish to submit your bills and have your account set up, DBA)	2. Business phone#	2a. Business FAX#
3. Billing address (as it appears on your bills submitted to CVC and where payments should be mailed)	4. Business address (the physical location of the business)	
5. Contact person's name	6. Billing phone# (where we may call regarding your account/bills)	

7. ***CVC group payee provider #***

B. Individual or Organization Information – Attach copy of current license

1. Provider's name (Last, First, MI)	2. Specialty / Services provided		
3. Professional license/certification/registration number	4. License issue date	5. License expiration date	6. State where issued

C. National Provider Identifier (NPI) Information

1. Individual or Organization name	2. If for Subpart, provide Subpart name	3. Please check one Type I Individual ❑ Type II Organization ❑
4. NPI address		
5. NPI 10-digit Identifier _ _ _ _ _ _ _ _ _ _	6. If for Subpart, provider Subpart NPI 10-digit identifier _ _ _ _ _ _ _ _ _ _	
7. Taxonomy Codes _ _ _ _ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _ _
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***** **Mental health counselors must have a master's degree in a field of study related to mental health services including, but not limited to, social work, marriage and family therapy or mental health counseling.**

PROVIDER APPLICATION

The Crime Victims Compensation Program (CVC) is authorized by Washington State law, Title 7, Chapter 68, Revised Code of Washington (RCW), and is administered by the Department of Labor and Industries. Health care and other services are provided to CVC clients pursuant to Title 7, Chapter 68 RCW, Washington Administrative Code (WAC) Chapters 296-30, and 296-31, and policies adopted by the department, including medical coverage decisions. **To qualify for payment, a provider must have an active provider account number assigned by CVC.** To receive a provider account number, the provider must submit a signed CVC Provider Application to CVC, including all required supporting information. For group practices, a separate Provider Application is required for **each** provider who will be providing services to CVC clients.

The following information must be submitted with the Provider Application, a:

- **current copy of the provider's current professional license, certification or registration. Master level counselors must include a copy of academic degree;**
- **completed W-9 Form.**

A provider's account number will become inactive if CVC does not receive any bills from the provider for a consecutive **18-month period.** If the provider's account becomes **inactive**, the provider must **reactivate the account** prior to submitting bills by calling the CVC Provider Registration Section at 360-902-5377. A new W-9 Form is needed to reactivate an account, **only** if information on that form has changed. Providers with inactive accounts will not automatically receive department publications, such as Provider Bulletins, Provider Updates, rules. **Issuance of a provider number does not guarantee that all services billed by a provider will be paid by CVC. The department will purchase only covered services, provided by covered professionals.**

The provider agrees:

1. To meet and maintain all applicable state and/or federal licensing, certification or registration requirements to assure the department of the provider's qualifications to perform services.
2. To comply with Washington State Law Title 7, Chapter 68 RCW, and WACs, including but not limited to, Chapters 296-30, and 296-31, and policies adopted by the department, including fee schedules and medical coverage decisions.
3. That providing services to or filing an application for benefits on behalf of a crime victim who is covered under the department's jurisdiction, constitutes acceptance of the requirements of Title 7, Chapter 68 RCW, and WACs, including but not limited to, Chapters 296-30, and 296-31, and policies adopted by the department, including fee schedules and medical coverage decisions.
4. To bill CVC the provider's **usual and customary** charges for services rendered to CVC clients as required by Washington State law.
5. To bill primary or public insurance prior to billing CVC.
6. To accept the department's payment after primary or public insurance has been billed as complete renumeration for services provided to the CVC client as required by Washington State law. **The provider agrees not to bill a CVC client for**:
   a) services covered by CVC which are related to the crime victim's claim.
   b) the difference between the billed and paid charges; or
   c) the difference between the provider's customary fee and the department's fee schedule.

   In the event a provider believes additional funds are due, the provider may submit a Provider's Request for Adjustment Form to the department for consideration in accordance with the instructions contained on the Remittance Advice.
7. That if the provider receives payment from the department in error or in excess of the amount properly due under the applicable rules and procedures the provider will promptly return to the department any excess monies received. The department may audit the provider's records to determine compliance with the rules and regulations of the department as provided in Washington State law.
8. To maintain documentation and records for a minimum of five years to support the services and levels of services billed. The provider agrees that these records and supportive materials will be made available to the department upon request as provided in Washington State law.
9. To notify CVC immediately of any changes to information in this application or provider status (e.g., federal tax identification number, ownership, incorporation, address, etc.). **A change in ownership or federal tax ID number may require a new provider account number**

A provider will be held to all the terms of this application even though a third party may be involved in billing claims to the department. The department reserves the right to deny, revoke, suspend or condition a provider's authorization to treat CVC clients in accordance with Washington law.

Provider's Statement of Agreement

I (the provider), _____, **(print or type)** agree to abide by the terms of this application and by all applicable federal and Washington State statutes, rules and policies. I have enclosed with my application all required supporting information to establish a provider account, including: a current copy of my current license, certification or registration (if I am required to be licensed, certified or registered by my state licensing authority); and a completed W-9 Form.

Date	Title	Signature

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 /

Type of Business _____

L&I # / System / Ownership / L&I Provider #

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 _____

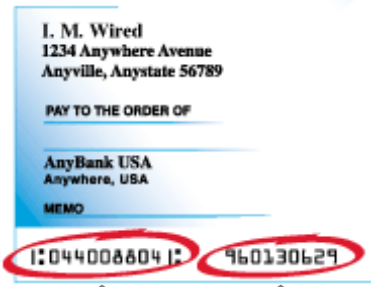
Financial Institution Phone Number _____

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.