STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
PO Box 44322 ● Olympia Washington 98504-4322

IME Provider Account Application
New/Add Payee

Thank you for your interest in providing services to our workers. Attached you will find the Independent Medical Exam (IME) Provider Account Application. *To receive payment, you must be approved as an IME Provider and be assigned an IME provider account number.*

Practitioners, please submit the following documents:

- ☐ Application (2 pages)
- ☐ Signed and dated attestation (with explanation if applicable)
- ☐ Provider agreement (2 pages)
- ☐ IME Provider Exam Sites
- ☐ IRS Form W-9
- ☐ Current Certificate of successful completion of the *Medical Examiners' Handbook* test
- ☐ Commanding Officer approval if you are active duty military (to conduct IMEs and to testify)
- ☐ Current copy of the provider's curriculum vitae
- ☐ Copy of fellowship certificate(s) if applicable
- ☐ Documentation of required Continuing Medical Education (CME) hours if applicable

The Office of Financial Management (OFM) will need to register your Tax ID to issue payments. You will need to submit form to OFM for New Tax ID, Enrollment/Change for EFT payments, updates to the Legal Names associated with your Tax ID. OFM's forms can be found: https://ofm.wa.gov/it-systems/accounting-systems/statewide-vendorpayee-services.

It is the responsibility of the provider to submit the necessary forms to OFM directly. L&I cannot accept or forward OFM's documents on behalf of the provider.

For questions regarding OFM's forms or registration process, call 360-407-8180 or email PayeeRegistration@ofm.wa.gov.

Please note: Incomplete applications will be returned and electronic signatures cannot be accepted. The *Medical Examiners' Handbook* test must be completed within 6 months of application received date.

You will receive notification of your approval status by mail.

Additional information:

- IME and Impairment Rating information can be found on our website at www.Lni.wa.gov/IMEs
- State Fund Workers Compensation IME billing and payment questions, contact Provider Hotline at 800-848-0811.
- State Fund and Self Insured Medical Aid Rules and Fee Schedule at: www.Lni.wa.gov/Patient-Care/Billing-Payments/Fee-Schedules-and-Payment-Policies/
- Crime Victims IME billing and payment questions, contact Crime Victims at 800-762-3716.
- Crime Victims Compensation Fee Schedule at: www.Lni.wa.gov/Claims/Crime-Victim-Claims/Crime-Victim-and-Provider-Resources#Fee-Schedule-Information
- A list of all approved IME examiners and firms is online at https://secure.lni.wa.gov/imelookup/
- For questions about the application process, call 360-902-5131
- Mail completed application to the address below or fax to 360-902-4249:
  Provider Quality and Compliance
  PO Box 44322
  Olympia WA 98504-4322

Washington State Department of Labor & Industries

IME Provider Account Application
New / Add Payee

Mail or fax completed application to:
Provider Quality and Compliance
PO Box 44322
Olympia WA 98504-4322
Fax: 360-902-4249

A. Application Information

I am working:

☐ In Washington State ☐ Outside of Washington State: _____

B. Tax Reporting Information

1. Tax payer identification number (EIN or SSN – must match the IRS Form W-9 submitted with this application)

C. Payee Account and Billing Information

2. Business Name (name used on your bills)			
3. Contact Name	Contact Phone number		
4. Physical location of business Street address	City	State	Zip Code
5. Billing Address (where you want your check sent) Street address	City	State	Zip Code
6. Location Phone Number	7. Billing Phone Number		
8. Medical Director Name (Firms only)	9. Medical Director professional license number		

D. Practitioner Information

10. Provider's Name (Last, First, MI)	11. Gender ☐ Male ☐ Female	12. Date of Birth
List any other name(s) under which you have been known by reference, licensing and/or educational institutions:		
13. Type of license ☐ MD ☐ DO ☐ DC ☐ DDS/DMD ☐ DPM	14. Professional license number	
15. Practice specialty/subspecialty	16. DEA number	
17. Provider's mailing address Street address	City	State Zip Code
18. Provider's phone number	19. Provider's email address	
20. Foreign Language(s) you speak **fluently:**		

E. NPI Information

21. Individual provider's name	22. Individual NPI number

Applicant Name: _____

F. Medical Qualifications

1. Doctors licensed to perform medicine and surgery (MD), osteopathic medicine and surgery (DO), podiatric Medicine and surgery (DPM) must complete the following:

☐ I am certified by a board recognized by:

- ☐ American Board of Medical Specialties, name of board(s):

  _____

- ☐ American Osteopathic Assn. Bureau of Osteopathic Specialties, name of board(s):

  _____

- ☐ American Podiatric Medical Association, name of boards(s):

  _____

☐ I am not board certified:

- ☐ Have you completed a residency? ☐ Yes ☐ No (Attach Documentation)
- ☐ Are you in the process of completing your Board Certification? ☐ Yes ☐ No Anticipated Completion Date _____

2. Doctors licensed to practice chiropractic must complete the following:

- ☐ I served as an L&I chiropractic consultant for at least 2 years. Dates:

  _____

- ☐ I attended the department's Chiropractic IME Examiner seminar. New applicants must have attended in the previous 2 years. Dates attended:

  _____

3. Dental examiner applicants must complete the following:

- ☐ I have a minimum of two years of post-doctoral clinical experience. Dates:

  _____

G. Practice and Continuing Education Information

1. Do you currently provide patient related services (excluding IME's)? ☐ Yes ☐ No

   If yes, indicate how many hours – select only ONE reporting method below:

   Per week _____ Hours Per Month _____ Hours Per Year _____ hours

   If no, list the date you retired from direct patient care: _____

2. Name of Practice, Affiliation or Clinic:

3. Effective Date at primary practice location

4. Contact Name Contact Phone number

5. Practice Website

6. Additional practice location listed on CV? ☐ Yes ☐ No

7. Include Contact information for additional practice:

8. Are you currently active duty military? ☐ Yes ☐ No

9. Do you have approval to conduct IMEs and testify from your Commanding Officer? ☐ Yes ☐ No

   If yes, please attach a copy of the approval.

10. Do you currently provide a minimum of 768 hours of patient related services per year? ☐ Yes ☐ No

If no, you must submit documentation showing you have fulfilled the requirements for your respective state licensure since your last renewal per WAC 296-23-317(3). Submit documentation of CE hours indicating the name of course, date and hours earned.

Labor and Industries IME Attestation Questions — to be completed by the practitioner

Please answer all of the following questions. If your answer to any of the following questions is "Yes", provide details as specified on the attached Professional Liability Action Page. ***If you attach additional sheets, sign and date each sheet.***

A.	**PROFESSIONAL SANCTIONS**	
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?	
	a. License to practice any profession in any jurisdiction?	☐ Yes ☐ No
	b. Other professional registration or certification in any jurisdiction?	☐ Yes ☐ No
	c. Specialty or subspecialty board certification	☐ Yes ☐ No
	d. Membership on any hospital medical staff	☐ Yes ☐ No
	e. Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	☐ Yes ☐ No
	f. Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national, or international regulatory agency or any public program	☐ Yes ☐ No
	g. Professional society membership or fellowship	☐ Yes ☐ No
	h. Participation/member in HMO, PPO, IPA, PHO, or other entity	☐ Yes ☐ No
	i. Academic appointment	☐ Yes ☐ No
	j. Authority to prescribe controlled substances (DEA or other authority)	☐ Yes ☐ No
2.	Have you been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?	☐ Yes ☐ No
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?	☐ Yes ☐ No
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?	☐ Yes ☐ No
B.	**CRIMINAL HISTORY**	
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?	☐ Yes ☐ No
	a. Do you have notice of any such anticipated charges?	☐ Yes ☐ No
	b. Are you currently under governmental investigation?	☐ Yes ☐ No
C.	**AFFIRMATION OF ABILITIES**	
1.	Do you presently use any drugs illegally?	☐ Yes ☐ No
2.	Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodation required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards or professional performance.	☐ Yes ☐ No
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement, with or without reasonable accommodation, according to the accepted standards of professional performance?	☐ Yes ☐ No
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY**	
1.	Have allegations or claims or professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?	☐ Yes ☐ No
2.	Have you or an insurance carrier ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?	☐ Yes ☐ No
3.	Are there any such claims being asserted against you now?	☐ Yes ☐ No
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?	☐ Yes ☐ No

I warrant that all the statements made in this form and on any attached informational sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of application or cause for administrative action.

Print Practitioner Name	Practitioner Signature (No Electronic Signature)	Date

Professional Liability Action Detail – Confidential Does Not Apply ☐

Practitioner Name (Print or Type)

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.

Date of Incident:

Clinical Details of the incident, with preceding events:

_____

_____

_____

_____

_____

_____

Your role and specific responsibility in the incident:

_____

_____

_____

_____

_____

_____

Subsequent events, including patients outcome

_____

_____

_____

_____

_____

Date suit of claim was filed:

Name of Insurance Carrier that handled the claim:

Address of above carrier City State Zip Code

Your status in the legal action ☐ Primary Defendant ☐ Co-Defendant ☐ Other _____

Current status of suit or other action:

Date of settlement, judgment or dismissal:

If case was settle out of court, or with a judgement, settlement amount attributed to you? $

Print Practitioner Name Practitioner Signature (No Electronic Signature) Date

IME Provider Agreement

The Industrial Insurance Program is authorized by Washington State law, Title 51 Revised Code of Washington (RCW), and is administered by the Department of Labor and Industries. IME services are provided according to Title 51 RCW, Washington Administrative Code (WAC) Chapter 296-23, and policies by the department, including medical coverage decisions.

Issuance of a provider number does not guarantee that all services billed by a provider will be paid by the department. Payments will be made according to the department Medical Aid Rules and Fee Schedule as updated annually and according to department policy. The department will only reimburse for covered services, provided to injured workers by approved providers.

I (the IME provider), _____
(print or type name)

agree to and accept all the terms of this agreement and to follow all applicable federal and Washington State statues, rules, and policies. I will provide independent, objective and timely medical opinions for all IMEs I conduct. I understand that it is the expectation of the department that all workers will be treated with dignity and respect. I understand that my performance will be measured by the quality of my examination and report, and not by whether my recommendations are perceived as favorable or unfavorable to the parties involved. I understand that the approval of my application does not guarantee that I will receive any IME referrals from the department.

The provider agrees:

1. To meet and maintain all applicable state and/or federal licensing or certification requirements to assure the department of the provider's qualifications to perform services for injured workers.

2. To comply with Washington State Law Title 51 RCW, Washington Administrative Code (WAC), including but not limited to Chapter 296-23 and policies adopted by the department, including fee schedules and medical coverage decisions. The provider who treats or provides a service to an injured or ill worker who is covered under the department's jurisdiction, accepts the requirements for Title 51 RCW, and the WACs, including but not limited to Chapter 296-20, 296-21, 296-23, and 296-23A, and policies adopted by the department, including fee schedules and medical coverage decisions.

3. To be reasonably available to testify at the Board of Industrial Insurance Appeals (Board) or by deposition. Reasonably available to all parties means cooperation in the timely scheduling of the pre-testimony conference and testimony.

    a. Doctor testimony is preferred to be taken in person and may be required by an Industrial Appeals Judge. Examiners who travel to conduct exams in Washington must be willing and able to return to testify if called to do so.

4. To accept the department or self-insured employer's payment as sole and complete remuneration for services provided to the worker as required by Washington State law. The provider agrees not to bill a worker for:

    a. Services covered by the industrial insurance program which are related to the industrial injury or occupational disease;
    b. The difference between the billed and paid charges.

    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.

5. To return promptly to the department or self-insurer any excess monies received as payment from the department or self-insurer in error or in excess of the amount properly due under the applicable rules and policies. The department may audit the provider's records to determine compliance with the rules and regulations of the department as provided by Washington State law.

6. To maintain documentation and records for a minimum of five (5) years to support the services provided 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 by Washington State law.

7. To notify the department immediately of any change to information in the application or provider status (e.g. any new actions against your professional license, federal tax identification number, ownership, incorporation, address, etc.). Any change in ownership or federal tax ID will require a new IME provider account application.

8. I will provide quality care that is respectful, equitable and responsive to diverse cultural health beliefs, practices, preferred languages, and communication needs in accordance with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

A provider will be held to all the terms of this agreement 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 an IME provider's authorization to provide IME services to injured workers.

Agreement to Code of Ethics

I further agree:

1. To learn and adhere to the standards of ethical conduct as listed in RCW 42.52.140 (Gifts) and RCW 42.52.150 (Limitations of Gifts).

2. To not offer any gift, gratuity, or favor to any department employee to include food and other refreshments.

3. To not seek to unduly influence the actions or decisions of the department employees.

4. To report any incidence of unethical conduct or abuse of position by a department employee to the Manager of Provider Quality and Compliance, Health Services Analysis, Department of Labor and Industries.

5. To accept that a failure to meet these standards of ethical conduct could result in adverse administrative action by the department and/or criminal actions per RCW 51.48.280 and Title 9A.68.

By signing, I accept the terms of this agreement and attest that this application and all attachments are accurate and true to the best of my knowledge.

Print Applicant's Name	Applicant's Signature (No Electronic Signature)	Date

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