



Provider Accounts & Credentialing
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Out of Country Provider Account Change Form

**For L&I Use Only –
 Provider Account #**

1. Account Information (Required)

| | |
|---------------------------------|--------------------------|
| Provider/Business/Facility Name | Email Address |
| L&I Provider Account Number | L&I Group Account Number |

2. Change the Name on My Account(s): If you are changing the name of the individual, then you must attach documentation: medical license, certification, marriage license, divorce decree, or court order. You do not need documentation to change your business name.

| | |
|--|-------------------------------------|
| Previous Provider/Business/Facility Name | New Provider/Business/Facility Name |
|--|-------------------------------------|

3. Change the Address of My Office’s Location: Include country code with the phone and fax numbers.

| Old Location | | New Location (This address cannot be a PO Box) | |
|--------------|------------|--|------------|
| Address | | Address | |
| City | State ZIP | City | State ZIP |
| Country | | Country | |
| Phone Number | Fax Number | Phone Number | Fax Number |

4. Change My Payment Address: Include country code with the phone and fax numbers. To change this address you must submit these additional forms with the Change Form:

- [Out of Country Statewide Payee Registration form](#) and
 - [W-8BEN form](#) (individual providers only) or
 - [W-8BENE form](#) (hospitals, facilities or clinics who receive payment).

| Old Payment Address | | New Payment Address (PO Box accepted) | |
|---------------------|------------|---------------------------------------|------------|
| Address | | Address | |
| City | State ZIP | City | State ZIP |
| Country | | Country | |
| Phone Number | Fax Number | Phone Number | Fax Number |

5. Change My Correspondence Address: Include country code with the phone and fax numbers.

| Old Correspondence Address | | New Correspondence Address (PO Box accepted) | |
|----------------------------|------------|--|------------|
| Address | | Address | |
| City | State ZIP | City | State ZIP |
| Country | | Country | |
| Phone Number | Fax Number | Phone Number | Fax Number |

6. Inactivate My Provider Account

| | | |
|-----------------------------|---------------------------------|----------------|
| L&I Provider Account Number | Provider/Business/Facility Name | Effective Date |
| Reason: | | |

7. I authorize this change by signing below: (Required)

| | | |
|-----------|--------------|------|
| Signature | Phone Number | Date |
|-----------|--------------|------|