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 a DME Supplier, Hospital, Pharmacy, Laboratory, Nursing Home, etc.
- Vendors such as Transportation, Schools, On-the-Job Training Sites, 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 and all 4 pages must be submitted.
- ☐ A current IRS Form W-9
- ☐ A copy of your license or certification as required by your state health regulations
- ☐ Submit Vendor Payee Registration forms directly to the Office of Financial Management(OFM)
- ☐ On the OFM Vendor/Payee Registration form, circle **MIPS use only** on the top right corner
  - The will insure your Vendor/Payee number is associated to your L&I provider account

Note:

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.

Detailed instructions are included at the end of the application. 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

- 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.)
- 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
- 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
- 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
  - Phone Number — the number L&I can call with billing questions
  - Fax Number — the number L&I can use to fax billing documentation
- 1099 Address:
  - Must match the address listed on your IRS Form W-9, where we will mail your Form 1099 at the end of the year
  - Legal name should match the name listed on your IRS Form W-9 submitted with your application
- Correspondence Address:
  - Correspondence Address — this is where L&I will send all general mail
  - Phone Number — the number L&I can call to contact the provider/office staff
  - 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.)

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

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

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

E. IRS Form W-9

- The address on this form will be used to mail your Form 1099 at the end of the year
- Signatures must be handwritten; electronic or stamped signatures are not accepted
- The Tax ID on section A.2 of the Provider Account Application must match the Tax ID on the IRS Form W-9

Important Information

The Office of Financial Management (OFM) will need to register your Tax ID to issue payments. You will need to submit Vendor/Payee forms to OFM for:

- New Tax ID
- Enrollment/Change for EFT payments
- Updates to the Legal Name associated with your Tax ID
- The Tax ID on OFM's Vendor/Payee forms must match the Tax ID on Section A.2 of the Provider Account Application
- OFM's forms can be found by following the link below: https://ofm.wa.gov/it-systems/accounting-systems/statewide-vendorpayee-services

The OFM forms must be completed concurrently with the submission of the Provider Account Application to avoid potential delays in payment.

OFM's forms can be found by following the link below:
https://ofm.wa.gov/it-systems/accounting-systems/statewide-vendorpayee-services

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

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.

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

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. 1099 Address – where we will mail your Form 1099 at the end of the year: This information must match what is on your IRS Form W-9

Address (as shown on you income tax return)	Legal name associated with Tax ID (per IRS Form W-9)
City	State Zip Code

6. 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 https://lni.wa.gov/patient-care/provider-accounts/become-a-provider/become-an-interpreter 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
https://secure.lni.wa.gov/provdir/

Crime Victims
☐ Yes ☐ No
https://lni.wa.gov/claims/crime-victim-claims/find-a-doctor-or-provider-for-crime-victims/

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

Department of Labor and Industries
Provider Accounts and
Credentialing
PO Box 44261
Olympia WA 98504-4261

Fax: 360-902-4563

Provider Agreement

I (provider) _____ , (**print or type**) agree to abide by the terms of this agreement, which pursuant to RCW 51.36.010 has the force of a contract, and by all applicable federal and Washington State statutes, rules and policies. I understand and agree to the following:

1. **Treatment.** I understand that I am responsible for the quality of care that I provide and will use my best medical judgment in providing that care. I further agree that I will provide services that comply with Washington law, Department of Labor and Industries (Department) rules and policies including medical coverage decisions, and Department treatment guidelines. In addition to general laws and rules about medical treatment, I agree I will provide services that comply with specific laws and rules regarding treatment of injured workers found in: Title 51 RCW (Industrial Insurance Act), WAC 296-20 (Medical Aid Rules), WAC 296-21 (Reimbursement Policies: Psychiatric, Biofeedback, Physical Medicine), 296-23 (Radiology, Radiation Therapy, Nuclear Medicine, Pathology, Hospital, Chiropractic, Physical Therapy, Drugless Therapeutics and Nursing – Drugless Therapeutics, etc.), 296-23A (Hospitals), and 296-23B (Ambulatory Surgery Center Payment). I further agree that 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. Providers are required to ensure spoken and sign language access according to Title VI of the Civil Rights Acts of 1964 and the Americans with Disabilities Act (ADA). Interpreting for an injured worker or a crime victim is covered by L&I and does not require prior authorization.

   Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance. This includes discrimination based on limited English proficiency (LEP) persons. As a result, recipients and sub-recipients of Federal financial assistance are responsible for taking reasonable steps to ensure meaningful access by LEP persons to the recipients' and sub-recipients' programs or activities, including the use of an interpreter. Failure to do so constitutes illegal discrimination and is a violation of an individual's civil rights. Since L&I is the recipient of Federal funding, medical providers and others whom L&I pays are sub-recipients.

2. **Opioid Treatment.** I acknowledge that I am responsible for understanding the Department opioid treatment guidelines and rules. I agree that if I prescribe opioids to injured workers I will comply with the Guidelines for Prescribing Opioids to Treat Pain in Injured Workers and the Department rules for opioids to treat noncancer pain (WAC 296-20-03030-03085). I understand and agree that should I fail to comply with the Department Guidelines for Prescribing Opioids to Treat Pain in Injured Workers and the Department

rules for opioids to treat noncancer pain (WAC 296-20-03030-03085), the Department can immediately terminate this agreement. I further agree that in the event of termination of this agreement under Section 13, I will not prescribe opioids to treat injured workers except for an initial visit or hospital emergency room visit under Chapter 51.36.010(2)(b).

3. **Referrals and Consultations.** If I am a medical provider, I agree to timely refer injured workers for consultations and treatment only to other Medical Network Providers, as required by WAC 296-20-015(2)(a), WAC 296-20-051, and WAC 296-20-065 or when it is in the injured worker's best interest. A list of Medical Network Providers is available at Find a Doctor.

4. **Communication and Cooperation**. I agree to cooperate with the Department in the management of its Medical Provider Network, timely communicate and comply with requests made of me in that regard, including mentoring, monitoring, and additional training. I understand that care for injured workers involves more than the provision of medical treatment and agree to timely communicate in a manner that promotes effective claims management with the Department, employers, and others who are involved in administering injured workers' claims. I will timely respond to questions, requests for information or records, review information provided by the Department, and complete and timely file required reports or chart notes, and other forms as requested. I understand that I am required to provide all medical records deemed relevant by the Department under RCW 51.36.060. I understand that if I fail to follow Department rules or deliver care that creates imminent harm to the worker the Department may exercise its authority under WAC 296-20-065 and WAC 296-20-03015.

5. **Billing.** I will bill according to the Department's billing rules and policies and understand that payments will be made according to L&I's Medical Aid Rules and Fees Schedules (MARFS) which were in effect at the time the service was rendered. If my usual and customary fee for any particular service is lower to the general public than listed in the fee schedules, I will bill the Department or Self-Insured employer at the lower rate. I certify that all services provided are related to the industrial injury, occupational disease, or injury covered by the Crime Victims Act. I understand that Crime Victims compensation is secondary to any public or private insurance the victim may have.

6. **Payment.** I agree to accept payment from the Department, Crime Victims program, or the Self-Insured Employer as sole and complete payment for covered services in accordance with WAC 296-20-010 I specifically agree not to bill the patient for any difference between the Department, Crime Victims, or Self-Insured allowable fee and my usual and customary charge, or to bill injured workers for any treatment of an accepted industrial condition.

7. **Overpayment.** If I receive payment from the Department or from a Self-Insured employer in error or in excess of the amount properly due, I will promptly notify the Department and return such excess amounts to the Department or the Self-Insured Employer.

8. **Underpayment.** If I believe additional funds are due, I will submit a provider request for adjustment form within the timelines specified in the rule or on the remittance advice.

9. **Records/Audits.** I agree to complete and maintain all records to fully justify and disclose the extent of the services or items furnished and bills submitted. I will maintain these records for a minimum of five years. I understand and agree that the Department may audit, review, or investigate services and treatment provided under this agreement. I understand that should I fail to retain, maintain, or provide access to the Department, the Department may recover payments not adequately documented or take other action.

10. **Maintain Standards and Notify Department of Changes.** I meet and will maintain all required licenses, permits, certifications, governmental or board authorizations, hospital privileges (if applicable), required insurance, and the Departments health care provider standards, and will notify the Department in writing within 14 days of any change. This includes but not limited to: a change in practice location, or contact information, my provider status, (e.g. Licensing, certification, registration, disciplinary action, limitation to privileges); federal tax information changes; and location, payment or correspondence addresses. Department health care provider standards may be found in WAC 296-20-01030 (Minimum Health Care Provider Network Standards) and WAC 296-20-01040 (Health Care Provider Network Continuing Requirements).

11. **Re-Credentialing**. I understand the Department does continuous monitoring on all providers which includes a background check. If I am a provider in the Medical Provider Network, I agree to provide the Department with my current malpractice insurance certificate, or any other information deemed relevant to provider monitoring in the Medical Provider Network.

12. **Automatic Renewal.** Upon successful completion of re-credentialing, I understand that this agreement will automatically renew unless the Department provides me written notice of material changes to this agreement, provides written notice of non-renewal or termination, or unless I no longer meet minimum standards or I am no longer enrolled in the Department's Medical Provider Network.

13. **Termination.** I understand and agree that the Department reserves the right to deny, revoke, suspend or place condition on my authorization to treat a worker or crime victim in accordance with Washington State Law. If I am a Medical Network Provider and I no longer meet the network standards in WAC 296-20-01030 (Minimum Standards) and WAC 296-20-01040 (Health Care Provider Network Continuing Requirements), if the Department finds Risk of Harm pursuant to WAC 296-20-01100, if I violate a material term of this agreement, or if I am no longer a member of the Department's Medical Provider Network. I understand that I may terminate this agreement at any time without cause upon 90 days written notice to the Department.

14. **Services after Termination**. Upon termination of this agreement through a final Department order, final order of the Board of Industrial Insurance Appeals, final court order, or a settlement or withdrawal agreement, I agree that I will not provide any treatment to injured workers except for an initial office visit or treatment I provide in a hospital emergency room under Chapter 51.36.010(2)(b). I acknowledge and agree that the Department will not pay for services I provide to injured workers after the effective date of termination unless for an initial office visit or treatment I provide in a hospital emergency room.

15. **Protest and Appeals.** If I disagree with or believe a decision, determination, or order of the Department is incorrect, I may protest or appeal in writing pursuant to Chapter 51.52. I understand and acknowledge that should I fail to timely protest or appeal a decision, determination or order, that such failure will result in the action, determination or directive contained in the order becoming final and binding.

I 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 my current licenses and certifications.

Once I sign, this agreement will become effective ONLY upon the Department's approval of my provider application and/or, my enrollment into the Department's Medical Provider Network. Upon Department approval, this agreement will supersede any previously signed provider agreement that I may have had with the Department.

My signature below indicates that I have fully read this document and voluntarily agree to the terms.

Print or Type Name	Title

Signature	Date

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