STATE OF WASHINGTON

DEPARTMENT OF LABOR AND INDUSTRIES

Insurance Services - Health Services Analysis - PO Box 44261, Olympia, WA 98504-4261

Dear Provider,

Thank you for your interest in providing services to our workers who are employed by a Washington State company. This application is for our out-of-country providers.

To receive payment, a provider must have an active provider account number. **To apply, you will need to complete and submit the following forms:**

- ☐ An Out-of-Country Provider Account Application (F248-361-000).
- ☐ A signed copy of the Provider Agreement (page 4).
- ☐ An Out-of-Country Statewide Payee Registration Form (F248-369-000).

  Note:
  - L&I cannot accept any forms with crossed out or whitened out information.
  - The legal name and payment address in Step 1 must match the legal name on the W-8BEN forms and the payment address in Section A of the Out-of-Country Provider Account Application.
- ☐ One of the following W-8BEN forms:
  - **W-8BEN** form must be completed by **individual providers** (attached) ***or***
  - **W-8BEN-E** – For **hospitals, facilities or clinics** who receive payment.
    - To download and complete this form, visit: https://lni.wa.gov/patient-care/provider-accounts/become-a-provider/#out-of-country-provider-application.
- ☐ A copy of your license or certification required by your country's health regulations.

What's Next?

After we process your application, we will send you a welcome letter containing your L&I provider account number. This is the number that you will need to use when you bill L&I.

Need more information? Contact:

- For questions about Provider Accounts & Credentialing, email: PACMail@Lni.wa.gov.
- For billing & payment questions, email: ForeignProviders@Lni.wa.gov.
- For additional provider information, including the most current version of the Medical Aid Rules and Fee Schedule (MARFS), visit www.Lni.wa.gov/FeeSchedules.
- For information about electronic billing, visit www.Lni.wa.gov/ElectronicBilling.

Sincerely,

Provider Accounts and Credentialing Unit

Application Instructions

The following describes the information you need to provide in each section of the Out-of-Country Provider Application.

A. Account and Billing Information

1. Business name that you will use when billing L&I.
2. Business phone number where we can contact you about billing questions.
   - Please include your country code (area code).
3. Business fax number where we can fax information to you if needed.
   - Please include your country code (area code).
4. Business location address (physical address of your business). This cannot be a PO Box.
5. Payment address where you want your payments mailed.
6. Contact person's name, phone number, and email address where we can contact you regarding your account or bills.

B. Individual Provider or Organization Information

1. Provider's name — last name followed by the first name or the facility name.
2. Specialty/Services provided — the type of services the provider or organization provides.
3. Professional license number of the provider or the facility.
   - **Providers: Attach a copy of your license with the application.**
   - **Facilities: Attach a copy of your facility license, certification, and/or accreditation.**
4. License issue date — the date your license was issued.
5. License expiration date — the date your license expires.
6. Country in which your license was issued.

C. Provider Specialty Information

1. Check one of the specialties or services you provide.
2. Other specialized information — write any additional information about your specialties or services here.

D. Provider Agreement Page

1. Read and sign the provider agreement page (page 4).

Washington State Department of Labor & Industries

Out of Country Provider Account Application

Mail or fax completed applications to:

Fax: 360-902-4484

Provider Accounts & Credentialing
PO Box 44261
Olympia WA 98504-4261
United States of America

For L&I Use Only – Provider Account Number

A. Account and Billing Information

1. Business Name	2. Business Phone Number	3. Business Fax Number
4. Business Location Address	5. Payment Address	

6. Billing Contact Person's Name	Phone Number (include country area code)	Email Address

B. Individual Provider or Facility Information – Attach a copy of your license or certification

1. Provider Name (Last, First, Middle initial)	2. Specialty/Services Provided
3. Professional License Number	4. License Issue Date
5. License Expiration Date	6. Country

C. Provider Specialty Information – Check one of the specialties or services that you provide.

☐	Adult Family Home	☐	Licensed Massage Therapist
☐	Ambulance	☐	Nursing Home
☐	Ambulatory Surgery Center	☐	Occupational Therapist
☐	Advanced Registered Nurse Practitioner	☐	Optician
☐	Audiologist	☐	Optometrist
☐	Chiropractor	☐	Osteopathic Physician
☐	Certified Registered Nurse Assistant	☐	Physical Therapy
☐	Dentist	☐	Physician
☐	Drug and Alcohol Treatment	☐	Prosthetist / Orthotist
☐	Durable Medical Equipment Supplier	☐	Psychiatric Hospital
☐	Head Injury Program	☐	Psychologist
☐	Hospital	☐	Registered Nurse First Assistant
☐	Interpreter	☐	Registered Nurse
☐	Lab Facility	☐	Other: ____________________

Other specialized information:

D. Provider Agreement

I have read, understand, and agree to:

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 possess impairment due to chemical or substance abuse or dependency.
- I certify that I do not possess a history of loss of license, certification, or registration.
- I certify that I do not possess loss or limitation of privileges.
- I certify that I do not possess felony convictions.

Account maintenance

- I certify that the information in this application is correct.
- I agree to notify L&I immediately in writing of any changes to the information in this application including but not limited to provider status (for example: licensing, certification, registration, disciplinary action, limitation of privileges); and physical or billing addresses.
- I understand that L&I reserves the right to deny, revoke, suspend, or place conditions on my authorization to treat workers or crime victims in accordance with Washington State law.

Billing

- I agree to accept the Department's or 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 the policies in the Medical Aid Rules and Fee Schedule (MARFS).
- I agree to bill the Department or the 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 statutes, 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.

Signature	Title	Date

Statewide Payee Registration

Only for Out-of-Country Providers

Washington State Department of Labor and Industries

Please read the following instructions before completing the form:

- The legal name on all forms must match.
- Please use **dark blue** or **black ink** when signing and filling out the forms by hand.
- Please fill out **all pages** of this form in their entirety, even if some information has not changed.

Statewide Vendor Number (if known):

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

STEP 1: Enter information about the payee and contact person

Legal Name of Payee	**SSN OR EIN**
Business Name, if different from Legal Name above – e.g. Doing Business As (DBA) Name	**Contact Person**
Payment Address (number, street, and apt or suite no., or P.O. Box or rural route)	**Contact Telephone Number (include extension)**
City or town, State or Province, and Zip or Postal Code where appropriate	**Contact Fax Number**
Email to receive Statewide Vendor Number and payment notifications	**For L&I Use Only:** **2350 / MIPS / Y /** **L&I # / System / Ownership / L&I Provider #**
Type of Business (if non-profit or tax exempt, please submit your determination letter)	

STEP 2: Select Payment Option:

☐ Check via U.S. mail (terminates any previous banking information on file) **OR** ☐ Debit Card

For L&I Use Only (Debit Card option)

Financial Institution Name – must be a US institution	**Financial Institution Phone Number**
Routing Number	**Account Number**

This account is: ☐ Checking or ☐ Savings (will default to checking if no option is selected)

Account Type: ☐ PPD (Personal) or ☐ CCD (Corporate/Business)

Authorization for Debit Card/Direct Deposit:

I hereby authorize and request the Office of Financial Management (OFM) 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, OFM 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, OFM will notify this office of the error and the reason for the reversal. This authority will continue until such time OFM 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) — Not to be signed by your financial institution	Title
SIGNATURE of Authorized Representative	Date

No stamped or electronic signatures will be accepted.

Instructions for the Statewide Payee Registration Form for Out-of-Country Providers

The term 'payee' refers to an individual or business that will receive 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.

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 Statewide Vendor Number (SWV), please enter it on the indicated line of the form.

Step 1: Payee & contact information

- **Legal name of payee** – **must match your legal name** on the Provider Account Application (and the Payment Method Authorization form if you sign up for a debit card).
- **Business name** – "doing business as" name. Enter only if different from legal name.
- **Payment address** – must match your payment address on the Provider Account Application (and the Payment Method Authorization form if you sign up for a debit card). Enter only one (1) address.
- **Email for contact person** - enter the email address we should use to communicate with you.
- **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.
- **Type of business** – enter the primary occupation of the payee.

Step 2: Payment options

Payments will be sent via U.S. mail. For providers in Mexico only: indicate whether you want to receive payments via U.S. mail or receive payment via a debit card. If no option is selected, then payments will default to a check in the U.S. Mail.
Note: Hospitals, facilities, and clinics are not eligible for the debit card option.

Step 3: W8-BEN for Individual Providers

The W-8BEN form is required *to process your registration and verify any changes to your account.*
Note: Hospitals, facilities, and clinics must complete form W-8BEN-E.

Part I – Identification of Beneficial Owner

1. Name of individual/beneficial owner **– must match your legal name** on the Provider Account Application (and the Payment Method Authorization form, if you sign up for a debit card).
2. Country of citizenship
3. Permanent residence address – enter your payment address. **Must match your legal name** on the Provider Account Application (and the Payment Method Authorization form, if you sign up for a debit card).
4. Mailing address, city, state and ZIP
5. U.S. Taxpayer Identification Number (SSN or ITIN), if applicable.
6. Foreign tax identifying number, if applicable
7. Reference number, if applicable
8. Date of birth (**required**)

Part II – Claim of Tax Treaty Benefits

9. Country, (i.e. Mexico, Jamaica)
10. Article Paragraph and withholding (Article 7, 0%).

Part III - Certification

11. **Sign and date** the Statewide Payee Registration and W-8BEN form

Step 4: Submit completed forms to one of the following:

Fax: 360-902-4484	**Mail**: Provider Accounts & Credentialing PO Box 44261 Olympia, WA 98504-4261 United States of America

If you have questions, contact Provider Accounts & Credentialing. Email PACMail@Lni.wa.gov or call 360-902-5140 and select option 4.

Form **W-8BEN**

(Rev. July 2017)

Department of the Treasury
Internal Revenue Service

Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding and Reporting (Individuals)

▶ **For use by individuals. Entities must use Form W-8BEN-E.**
▶ **Go to *www.irs.gov/FormW8BEN* for instructions and the latest information.**
▶ **Give this form to the withholding agent or payer. Do not send to the IRS.**

OMB No. 1545-1621

Do NOT use this form if:	**Instead, use Form:**
• You are NOT an individual	W-8BEN-E
• You are a U.S. citizen or other U.S. person, including a resident alien individual	W-9
• You are a beneficial owner claiming that income is effectively connected with the conduct of trade or business within the U.S. (other than personal services)	.W-8ECI
• You are a beneficial owner who is receiving compensation for personal services performed in the United States	8233 or W-4
• You are a person acting as an intermediary	W-8IMY

Note: If you are resident in a FATCA partner jurisdiction (i.e., a Model 1 IGA jurisdiction with reciprocity), certain tax account information may be provided to your jurisdiction of residence.

Part I Identification of Beneficial Owner (see instructions)

1 Name of individual who is the beneficial owner

2 Country of citizenship

3 Permanent residence address (street, apt. or suite no., or rural route). **Do not use a P.O. box or in-care-of address.**

City or town, state or province. Include postal code where appropriate.

Country

4 Mailing address (if different from above)

City or town, state or province. Include postal code where appropriate.

Country

5 U.S. taxpayer identification number (SSN or ITIN), if required (see instructions)

6 Foreign tax identifying number (see instructions)

7 Reference number(s) (see instructions)

8 Date of birth (MM-DD-YYYY) (see instructions)

Part II Claim of Tax Treaty Benefits (for chapter 3 purposes only) (see instructions)

9 I certify that the beneficial owner is a resident of ________________________________ within the meaning of the income tax treaty between the United States and that country.

10 **Special rates and conditions** (if applicable—see instructions): The beneficial owner is claiming the provisions of Article and paragraph ________________ of the treaty identified on line 9 above to claim a _____% rate of withholding on (specify type of income):

____ .

Explain the additional conditions in the Article and paragraph the beneficial owner meets to be eligible for the rate of withholding: ____________

____

Part III Certification

Under penalties of perjury, I declare that I have examined the information on this form and to the best of my knowledge and belief it is true, correct, and complete. I further certify under penalties of perjury that:

- I am the individual that is the beneficial owner (or am authorized to sign for the individual that is the beneficial owner) of all the income to which this form relates or am using this form to document myself for chapter 4 purposes,
- The person named on line 1 of this form is not a U.S. person,
- The income to which this form relates is:
  (a) not effectively connected with the conduct of a trade or business in the United States,
  (b) effectively connected but is not subject to tax under an applicable income tax treaty, or
  (c) the partner's share of a partnership's effectively connected income,
- The person named on line 1 of this form is a resident of the treaty country listed on line 9 of the form (if any) within the meaning of the income tax treaty between the United States and that country, and
- For broker transactions or barter exchanges, the beneficial owner is an exempt foreign person as defined in the instructions.

Furthermore, I authorize this form to be provided to any withholding agent that has control, receipt, or custody of the income of which I am the beneficial owner or any withholding agent that can disburse or make payments of the income of which I am the beneficial owner. **I agree that I will submit a new form within 30 days if any certification made on this form becomes incorrect.**

Sign Here ▶

Signature of beneficial owner (or individual authorized to sign for beneficial owner)

Date (MM-DD-YYYY)

Print name of signer

Capacity in which acting (if form is not signed by beneficial owner)