



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](http://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

**Return To:**

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

**(Please type or print clearly on all sections)**

Please  
check:

- New Provider
- Address Updates for Reactivation of Provider Account
- Tax ID Change – Effective Date \_\_\_\_\_

Required

(360) 902-5377 FAX (360) 902-5333

Internet address: <http://www.lni.wa.gov/FormPub>

**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<br>Type I Individual <input type="checkbox"/> Type II Organization <input type="checkbox"/> |
| 4. NPI address                     |   |   |
| 5. NPI 10-digit Identifier         | 6. If for Subpart, provider Subpart NPI 10-digit identifier |   |
| 7. Taxonomy Codes                  |   |   |
|                                    |   |   |

\*\*\*\*\* **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 remuneration 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 |
|------|-------|-----------|
|      |       |           |