Washington State Department of Labor & Industries

Medical Network Provider Application Packet

Provider Account and Credentialing
PO Box 44261
Olympia WA 98504-4261

This packet is for medical providers applying for the L&I Medical Provider Network. This packet includes:

- Network Credentialing Checklist (F245-445-000).
- Washington Practitioner Application (F245-411-000).
- Provider Agreement (F245-397-000).

To ensure you submit a complete application, please use the Credentialing Checklist.

Note that incomplete applications delay our processing and our payment for providers' services.

If you have any questions about the application process, please email us at ProvNet@Lni.wa.gov.

Washington State Department of Labor & Industries

Credentialing Checklist
L&I Medical Provider Network

To help you submit complete applications, here is a checklist of required documents and the information in them that is often forgotten or completed incorrectly. Note: Incomplete application delay our processing — and our payment to you for providers' services.

Required Documents	Double Check Your Information
☐ Washington Practitioner Application (WPA) www.lni.wa.gov/forms-publications/f245-411-000.pdf • Complete pages 1 — 14. • **Signature must be within the last 6 months.** • **Follow instructions on Page 1.**	☐ **Page 2:** Practice information must include: • Billing address • Organization NPI • Tax ID (must match Tax ID on the IRS Form W-9)
	☐ **Page 4 — 6:** Education Information must include: • Start/end dates of degree(s)
	☐ **Page 6:** Current Hospital Affiliation must be included, in applicable to specialty
	☐ **Page 8:** Work History must be complete. • Gaps in Education/Work History exceeding 6 months must be explained in Section 18
	☐ **Page 11 — 13:** Attestation Questionnaire: • Each question must be answered • If the provider has ever been subject to a National Practitioner Data Bank or State License report(s), you must answer "Yes" to question A4 • For each "Yes" answer, you must provide an explanation, regardless of when the event occurred • Signature date must be within the last 6 months
	☐ **Page 14:** Release of Information is missing, incomplete, or expired • Signature date must be within the last 6 months
☐ Provider Agreement lni.wa.gov/forms-publications/F245-397-000.pdf	☐ All 4 pages must be submitted together
	☐ Name must be printed, signed, and dated

Required Documents	Double Check Your Information
☐ IRS Form W-9 • The address on this document will be used to mail your Form 1099 at the end of the year	☐ IRS Form W-9 • Signatures must be handwritten; electronic signatures are not accepted • The Tax ID on Page 2 of the WPA must match the Tax ID on the IRS Form W-9
☐ The Office of Financial Management (OFM) will need to register your Tax ID to issue payments. You will need to submit forms to OFM for: • New Tax ID • Enrollment/Change for EFT payments • Updates to the Legal Name associated with your Tax ID Find forms and additional information at: ofm.wa.gov/it-systems/accounting-systems/statewide-vendorpayee-services For questions regarding forms or processes, call 360-407-8180 or email: PayeeRegistration@ofm.wa.gov	☐ OFM's Statewide Vendor/Payee Forms • The Tax ID on OFM's Vendor/Payee forms must match the Tax ID on page 2 of the WPA • On the Vendor/Payee Form, circle **MIPS use only** on the top right corner • This will ensure your Vendor/Payee number is associated to your L&I provider account • The OFM forms must be completed concurrently with the submission of the WPA to avoid potential delays in payment **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.**
☐ Current Malpractice Insurance Face Sheet	☐ Provider's name must be listed • Minimum Claim-Aggregate must be at least $1 – 3 Million ☐ If covered under Federal Tort or Group Self Insurance, proof of coverage must include: • Roster of covered providers, including the provider named on this submission
☐ Physician Assistant Delegation Agreement Plan wmc.wa.gov/licensing/applications-and-forms/physician-assistant-delegation-agreement	☐ Delegation Agreement Plan must be approved by the Washington State Department of Health ☐ Sponsor's WPA must currently be in process or approved into L&I's network ☐ Sponsor and PA-C must be listed under the same Tax ID

Questions?	**Send Completed L&I Forms To:**
Email: ProvNet@Lni.wa.gov **Where to Find Forms? Go to:** lni.wa.gov/patient-care/provider-accounts/become-a-provider/	Fax: 360-902-4563 Mail: Washington State Department of Labor & Industries PO Box 44261 Olympia WA 98504-4261

Washington Practitioner Application

To use the Washington Practitioner Application (WPA), follow these instructions:

- **Keep an <u>unsigned</u> and <u>undated</u> copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate.
- Please sign and date pages 11 and 13 .
- Please document any YES responses on the Attestation Question page.
- Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- Attach copies of requested documents each time the application is submitted.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- If a section does not apply to you, please check the provided box at the top of the section.
- Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to:

1. INSTRUCTIONS

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered. *<u>Please do not use abbreviations</u>*. **Current copies of the following documents must be submitted with this application:** (all are required for MDs, DOs; as applicable for other health practitioners).

- DEA Certificate
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application. Dates need to be listed in mm/yyyy Format)

**** All sections must be completed in their entirety. ****

2. PRACTITIONER INFORMATION – Legal Name Required

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions:			
Home Mailing Address:	City:		
	State: State	Zip Code: xxxxx-xxxx	
Home Telephone Number: ( )	Pager Number: ( )	Cell Phone Number: ( )	E-Mail Address: Email address
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):		Citizenship:
Social Security Number:	☐ Male ☐ Female	Languages Fluently Spoken by Practitioner:	
Have you ever voluntarily opted-out of Medicare? Yes☐ No ☐			
NPI:	Medicare Number: (WA)	Medicaid (DSHS) Number(s):	L & I Number(s):
Specialty primarily practicing:	Sub specialties primarily practicing:		
Other Professional Interests in Practice, Research, etc.:			

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

3. PRACTICE INFORMATION **CHECK ALL THAT APPLY**

Effective Date at PRIMARY Practice location (MM/YY) _____

Practice Setting

☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other

Practitioner Profile

☐ PCP ☐ Specialist ☐ Check if you are both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No

Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#:
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Practice Website			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		

Is the office wheelchair accessible? ☐Yes ☐No

Are you accepting new patients? ☐Yes ☐No

Have you limited your practice in any way (e.g. 18 years or older?)

☐Yes ☐No If yes, please explain:

_____

_____

Do you currently supervise ARNP's or PA's? ☐Yes ☐No

If yes, please provide the name and specialty below:

_____

_____

Please list languages fluently spoken by office staff:

_____

_____

Office Hours

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday:_____

Do you provide 24 hour coverage? ☐Yes ☐No

If no, please explain how your patients obtain advice and care after hours:

_____

_____

A. Hospital Inpatient Coverage Plan (for those without admitting privileges) **Does Not Apply** ☐

Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Office Covering Practitioners/Call Group **Does Not Apply** ☐

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

Effective Date at SECONDARY Practice location (MM/YYYY)	**CHECK ALL THAT APPLY**

Practice Setting
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other

Practitioner Profile
☐ PCP ☐ Specialist ☐ Check if you are both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No

Name of Secondary Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Practice Website			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		

Is the office wheelchair accessible? ☐Yes ☐No

Are you accepting new patients? ☐Yes ☐No
Have you limited your practice in any way (e.g. 18 years or older?)
☐Yes ☐No If yes, please explain:
_____
_____

Do you currently supervise ARNP's or PA's? ☐Yes ☐No
If yes, please provide the name and specialty below:
_____
_____

Please list languages fluently spoken by office staff:
_____
_____

Office Hours

Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____
Sunday:_____

Do you provide 24 hour coverage? ☐Yes ☐No
If no, please explain how your patients obtain advice and care after hours:
_____
_____

A. Hospital Inpatient Coverage Plan (for those without admitting privileges) **Does Not Apply** ☐

Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Office Covering Practitioners/Call Group **Does Not Apply** ☐

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

LIST OTHER OFFICE LOCATIONS WITH THE ABOVE INFORMATION ON A SEPARATE SHEET

4. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS

(Attach Additional Sheet if Necessary)

Washington State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Pharmacists Collaborative Drug Therapy Agreement (CDTA) Number(s):		
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued:

5. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS

State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

6. UNDERGRADUATE EDUCATION (*Do not abbreviate*) Does Not Apply ☐

School/College/University/Vocational Education:	Degree Received(be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:
College or University Name:	Degree Received(be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:

7. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION Does Not Apply ☐

Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): ( ) - ( )	Program or Course of Study:			
Faculty Director:	Degree:			

8. MEDICAL/PROFESSIONAL EDUCATION (*Do not abbreviate*)

Medical/Professional School:	Start Date: (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:

9. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary)			**Does Not Apply** ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

10. RESIDENCIES (Attach Additional Sheet if Necessary)			**Does Not Apply** ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

11. FELLOWSHIPS (Attach Additional Sheet if Necessary)			**Does Not Apply** ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

12. PRECEPTORSHIP (Attach Additional Sheet if Necessary)				**Does Not Apply** ☐
Institution:	Address:	City:	State:	Zip Code:
Telephone Number	Fax Number		Email Address	
Dates Attended (mm/yyyy - mm/yyyy): ( ) - ( )	Training:		Department Chairman:	

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13. FACULTY/TEACHING APPOINTMENTS (Attach Additional Sheet if Necessary)			**Does Not Apply** ☐	
Institution:	Address:	City:	State:	Zip Code:
Telephone Number	Fax Number		Email Address	
Dates Attended (mm/yyyy - mm/yyyy): ( ) - ( )	Position:		Faculty Director:	

14. BOARD CERTIFICATION				**Does Not Apply** ☐
Are you board or otherwise professionally certified?				
☐ **Yes** If "Yes", please complete below:	☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)

Have you applied for certification other than those indicated above? ☐ Yes ☐ No

If so, list certification and date:

Certification number if applicable:

If you participate in a specialty which does not have board certification, please indicate specialty:

15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

16. HOSPITAL, MILITARY, & OTHER INSTITUTIONAL AFFILIATIONS **Does Not Apply** ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) Current Hospital affiliation, (B) Previous Hospital Affiliations, (C) Current Military Affiliation, (D) Previous Military Affiliations (E) Applications in process This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

A. CURRENT HOSPITAL AFFILIATIONS (*Do not abbreviate*)	
Name of Primary Admitting Hospital:	Department:
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):

Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐

☐ **Primary practice admits only** ☐ **Secondary Practice admits only** ☐ **can admit to for all locations**

Name of Secondary Admitting Hospital:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date (mm/yyyy):

Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐

☐ Primary practice admits only ☐ Secondary Practice admits only ☐ Can admit to for all location**s**

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Name of Other Institutions:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date (mm/yyyy):

Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐
☐ Primary practice admits only ☐ Secondary Practice admits only ☐ Can admit to for all locations

B. PREVIOUS HOSPITAL AFFILIATIONS (Do not abbreviate)

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		
Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		
Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

C. CURRENT MILITARY AFFILIATIONS (Do not abbreviate) Please include Military Reserves

Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):

D. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)

Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):

E. APPLICATIONS IN PROCESS (*Do not abbreviate*)			
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted(mm/yyyy)	
Mailing Address:	City:	State:	Zip Code:

17. WORK HISTORY (*Do not abbreviate)*

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. Curriculum vitae is not sufficient.

Name of Practice / Employer:	Contact Name:			Telephone Number:	
Reason for Leaving:	Email Address			Fax Number:	
Mailing Address	City:	State:	Zip:	From (mm/yyyy)	To (mm/yyyy)
Name of Practice / Employer:	Contact Name:			Telephone Number:	
Reason for Leaving:	Email Address			Fax Number:	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Practice / Employer:	Contact Name:			Telephone Number:	
Reason for Leaving:	Email Address			Fax Number:	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

18. GAPS IN HISTORY. Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:

	From (mm/yyyy):	To (mm/yyyy):

19. PEER REFERENCES

List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who, through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency or fellowship for a period of less than three years, one reference must be from the Program Director. Allied Health Providers must provide at least one reference from their same discipline.

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional)	

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional)	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional)	

20. PROFESSIONAL AFFILIATIONS (*Do not abbreviate*)

Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
		☐ YES ☐ NO
		☐ YES ☐ NO

21. PROFESSIONAL LIABILITY (*Do not abbreviate*)

A. Current Insurance Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate) (Attach Additional Sheet if Necessary)

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

WASHINGTON PRACTITIONER 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 a separate sheet. *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/membership in an HMO, PPO, IPA, PHO, Health Plan 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 ever 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 accommodations 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 of professional performance.		YES ☐	NO☐
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES ☐	NO☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of 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 your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (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☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		YES ☐	NO☐

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature:_____ Date_____

Type or Print name here_____

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

22. 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 and clinical details of the incident, with preceding events: Date: Details:	
Your role and specific responsibility in the incident:	
Subsequent events, including patient's clinical outcome:	
Date suit or claim was filed:	
Name and Address of Insurance Carrier that handled the claim:	
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 settled out-of-court, or with a judgment, settlement amount attributed to you? **$**	

23. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

Review dates and initials:

_____

_____

_____

_____

_____

_____

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

Healthcare Organization: -
And/or Designated Agent:

WASHINGTON PRACTITIONER APPLICATION AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this authorization and release of information form in conjunction with the Washington Practitioner Application (WPA) and/or the Washington Practitioner Attestation or Credentials Update (CU) form, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Healthcare Organization(s)* indicated on the WPA for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications in a timely manner. I understand that the application will not be processed until the application is deemed complete by the healthcare organization.
2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to information exchange activities of the Healthcare Organization(s) as part of the verification and credentialing process.
3. I authorize all individuals, institutions and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Healthcare Organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with providing information, investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.
6. I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations, contractual agreements, and policies of the Healthcare Organization.

7 I acknowledge that I am responsible for notifying the Healthcare Organization of any changes/challenges to licensure, DEA, malpractice claims, criminal convictions, hospital privileges or other disciplinary actions.

8. I attest to the accuracy, currency and completeness of the information provided. I understand and agree that any misstatements in or omissions from the CU, WPA, Washington Practitioner Attestation and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.
9. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
10. I understand that completion and submission of the Authorization and Release does not automatically grant me membership or clinical privileges/participating status with the Healthcare Organization(s)* indicated on the WPA/CU or Attestation.
11. I hereby further authorize and consent to the release of information and/or reporting by the Healthcare Organization(s) to medical associations, licensing boards, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and other similar organizations regarding any pertinent information which the Healthcare Organization(s) may have concerning me as long as such release of information and/or reporting is done in good faith and without malice, and I hereby release from liability Healthcare Organization(s) and its staff and representatives for so doing.
12. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Reset

Date: _____

Healthcare Organization (e.g. hospital, medical staff, medical group, independent practice association, professional review organization health plan, health maintenance organization, preferred provider organization, physician hospital organization, medical society, credentials verification organization, professional association, medical school faculty position or other health delivery entity or system).

Healthcare Organization:
And/or Designated Agent:

WASHINGTON PRACTITIONER APPLICATION AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

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1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Healthcare Organization(s)* indicated on the WPA for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications in a timely manner. I understand that the application will not be processed until the application is deemed complete by the healthcare organization.

2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to information exchange activities of the Healthcare Organization(s) as part of the verification and credentialing process.

3. I authorize all individuals, institutions and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Healthcare Organization(s), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with providing information, investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.

6. I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations, contractual agreements, and policies of the Healthcare Organization.

7 I acknowledge that I am responsible for notifying the Healthcare Organization of any changes/challenges to licensure, DEA, malpractice claims, criminal convictions, hospital privileges or other disciplinary actions.

8. I attest to the accuracy, currency and completeness of the information provided. I understand and agree that any misstatements in or omissions from the CU, WPA, Washington Practitioner Attestation and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.

9. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

10. I understand that completion and submission of the Authorization and Release does not automatically grant me membership or clinical privileges/participating status with the Healthcare Organization(s)* indicated on the WPA/CU or Attestation.

11. I hereby further authorize and consent to the release of information and/or reporting by the Healthcare Organization(s) to medical associations, licensing boards, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and other similar organizations regarding any pertinent information which the Healthcare Organization(s) may have concerning me as long as such release of information and/or reporting is done in good faith and without malice, and I hereby release from liability Healthcare Organization(s) and its staff and representatives for so doing.

12. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

Healthcare Organization (e.g. hospital, medical staff, medical group, independent practice association, professional review organization health plan, health maintenance organization, preferred provider organization, physician hospital organization, medical society, credentials verification organization, professional association, medical school faculty position or other health delivery entity or system).

Modification to the wording or format of the WPA / Attestation / Authorization and Release may invalidate an application.

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

RESET