



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 injured workers. Attached you will find the Provider Application necessary for obtaining an account number with us. *To receive payment, a provider must have an active provider account number. A complete application is required for each individual provider.*

### **What do I need to submit?**

- Completed application.
- Signed Provider Agreement page.
- License or certification required by your country's health regulations.

### **What's next?**

After we process your application, you will receive a welcome letter.

- Changes to your account should be reported within 15 days to prevent delays in payment.

### **Need more information? Contact:**

- Provider Credentialing and Compliance at 360-902-5140 for question concerning your account.
- Provider Hotline at 800-848-0811 for billing and payment questions.
- For additional provider information, including the most current version of the Medical Rules and Fee Schedule, please visit: [www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched](http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched).

Thank you for treating Washington's injured workers.

Sincerely,

Gary Walker  
Provider Credentialing and Compliance

# Application Instructions

## 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.
3. Business fax number – where we can fax information to you if needed.
4. Business location address –physical address of your business. This can't be a PO Box.
5. Billing address – where you want your payments mailed.
6. Billing contact person – the name of the person we can talk to about billing issues.
7. Billing contact's phone number – where we can call regarding your account or bills.

## B. Individual Provider or Organization Information

1. Provider's name in the last, first name format or the organization's name.
2. Specialty/Services provided – the type of services the provider or organization provides.
3. Professional license number – the provider's professional license number. Attach a copy of your license with the application.
4. License issue date – the date your license was issued.
5. License expiration date – the date your license expires.
6. Country – the country your license was issued in.

## 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.

# Out of Country Provider Account Application

Mail or fax completed applications to:

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

Fax: 360-902-4484

## A. Account and Billing Information

1. Business name	2. Business phone number	3. Business fax number
4. Business location address	5. Billing address (where payment should be mailed)	
6. Billing contact person's name	7. Billing contact person's phone number (where we can call regarding your account/bills)	

## B. Individual Provider or Organization Information – Attach a copy of your professional license

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.

<input type="checkbox"/> Adult Family Home	<input type="checkbox"/> Dentist	<input type="checkbox"/> Interpreter	<input type="checkbox"/> Osteopathic Physician
<input type="checkbox"/> Ambulance	<input type="checkbox"/> DME Supplier	<input type="checkbox"/> Lab Facility	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Drug & Alcohol Treatment	<input type="checkbox"/> Licensed Massage Therapist	<input type="checkbox"/> Physician
<input type="checkbox"/> ARNP	<input type="checkbox"/> First Surgical Assist (RNFA)	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Prosthetist/Orthotist
<input type="checkbox"/> Audiologist	<input type="checkbox"/> Head Injury Program	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Hospital	<input type="checkbox"/> Optician	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> CRNA	<input type="checkbox"/> Psychiatric Hospital	<input type="checkbox"/> Optometrist	

**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 (e.g. 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 treated workers or crime victims in accordance with Washington State law.

### Billing

- I agree to accept L&I's payment as sole and complete remuneration for services provided to the worker as required by Washington State law.
- I understand that Crime Victims compensation is secondary to any public or private insurance the victim may have.
- I agree to bill L&I according the policies in the Medical Aid Rules and Fee Schedule (MARFS).
- I agree to bill L&I my usual and customary fee.
- I certify that all services provided are related to the industrial injury, occupation 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.

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Title

Signature

Date