



STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES

PO Box 44326 • Olympia, WA 98504-4326

Dear Vocational Provider,

Thank you for your interest in treating Washington's injured workers. This application is for vocational providers and groups.

To become a vocational provider, you will need to submit:

- A completed application. If you are a member of a group, each group member will need to submit an application and Vocational Provider Agreement.
- A signed copy of the Vocational Provider Agreement.
- A completed Statewide Payee Registration and W-9.
- A copy of your professional certification(s) if you are credentialed.

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. For more information on how to bill the department, please visit www.Lni.wa.gov/ClaimsIns/Providers/Billing.

We offer electronic billing. For more information, call the Electronic Billing Unit at 360-902-6511 or visit www.ElectronicBilling.Lni.wa.gov.

If you have any questions about this application, please contact us at 360-902-5140.

Thank you,

Private Sector Rehabilitation Services

Vocational Provider Application Instructions

This packet includes the following:

Vocational Provider Agreement

Vocational Provider Account Application

- Part B Vocational Employment Status Form
- Part C Vocational Provider Branch Identification Form
- Part D Pertinent Vocational Work History
- Part E Intern Supplemental Application

Statewide Payee Registration and W-9

Complete the application using 11 point font or clearly print using dark ink.

Vocational Provider Account Application

1. Tax Identification number or Social Security Number you will use when billing L&I.
2. Type of provider you are applying as
3. Business name that you will use when billing L&I.
4. Firm Provider number.
5. Street address of firm. This can't be a P.O. Box.
6. Individual provider branch contact number. May not be a cell phone number.
7. Individual provider's referral contact number. May be a cell phone number.
8. Vocational manager's name.
9. Contact person's name
10. Billing address as it appears on your bills submitted to L&I and where payments should be mailed.
11. Vocational manager's provide4r number
12. Business phone number
13. Billing phone where we may call regarding your account and bills.
14. Individual vocational provider information. What type of referrals you will accept.
15. Provider's Name
16. Certifications.
17. For VRC's, number of years of industrial insurance experience.
18. L&I VRC ID number

Interns need to complete the intern supplemental application that specifies

19. For interns, supervisor's name
20. For interns, supervisor's VRC ID number
21. For interns, supervisor's provider number
22. For supervisor or forensic status, number of years providing direct vocational services working with Washington industrially injured or ill workers.

Vocational Provider Agreement

The provider agrees:

- To meet and maintain all applicable state and/or federal licensing or certification requirements to assure the department of the provider's qualifications to perform services.
- To comply with Washington State Law [Title 51 RCW](#), Washington Administrative Code (WAC), including but not limited to, [Chapter 296-19A](#), and policies adopted by the department, including fee schedules.
- That providing services to an injured or ill worker who is covered under the department's jurisdiction, constitutes acceptance of the requirements of [Title 51 RCW](#), and the WACs, including but not limited to, [Chapters 296-19A](#), and policies adopted by the department.
- To accept the department's or self-insured employer's payment as sole and complete remuneration for services provided to the worker as required by Washington State law. **The provider agrees not to bill a worker for:**
 - Services covered by the industrial insurance program which are related to the industrial injury or occupational disease; or b) the difference between the billed and paid charges.
 - In the event a provider believes additional funds are due, the provider may submit a Provider's Request for Adjustment (Form F245-183-000) to the department for consideration in accordance with the instructions contained on the Remittance Advice.
- That if the provider receives payment from the department or self-insurer in error or in excess of the amount properly due under the applicable rules and procedures the provider will promptly return to the department or self-insurer 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.
- To maintain documentation and records for a minimum of five years to support the services provided 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.
- To notify the department 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 vocational provider account number.** If a new vocational provider account number is assigned, providers who bill electronically must also submit an electronic billing agreement and if billing through an intermediary, a Power of Attorney.

A provider will be held to all the terms of this agreement 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 injured workers in accordance with Washington Law.

Provider's Statement of Agreement

I, (the Provider) _____ (print or type) 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 to establish a vocational provider account, including: a current copy of my certification(s) (if I am certified); and a completed Form W-9. I understand that issuance of a provider number by the department does not guarantee I will receive any vocational referrals from the department.

Date

Title

Signature

Return to:
 Department of Labor and Industries
 Private Sector Rehabilitation Services
 Industrial Insurance State Fund
 PO Box 44326
 Olympia WA 98504-4326
 (360) 902-5140
 1-800-848-0811
<http://www.Lni.wa.gov>



Vocational Provider Account Application

Tax Reporting Information

1. Tax Payer Identification Number (EIN or SSN) *(This number must match the W-9 Form you submit)*

Application

2. I am applying as a *(Please check all that apply)*

Firm Manager VRC Forensic Supervisor Intern

Account and Billing Information

Administrative Information

3. Business name (as you wish to submit your bills and have your account set up, DBA)		4. Firm provider
5. Street address of firm (primary branch office served by this applicant)	10. Billing address (as it appears on your bills submitted to L&I and where payments should be mailed).	
6. Individual provider primary branch contact number <i>(cannot be cell phone #)</i>		
7. Individual provider referral contact number <i>(can be cell phone #)</i>		
8. Vocational manager's name (WAC 296-19A-210(7))	11. Voc manager's provider #	12. Business phone number
9. Contact person's name	13. Billing phone (where we may call regarding your account/bills)	

14. Individual Vocational Provider Information

I will accept referrals for: State Fund Self-Insured Both Neither

NOTE: Interns cannot receive referrals.

New Firms Only: Complete Part C, the Vocational Provider Branch ID Form

15. Provider's name (Last, First, MI)	
16. Certification (CRC, CDMS, ABVE) <input type="checkbox"/> Yes, Attach copy <input type="checkbox"/> No	17. For VRC's, number of years industrial insurance experience. # of years: _____ Complete enclosed pertinent work history form.
18. L&I VRC ID number (See instructions)	

Interns also need to complete the intern supplemental application.

19. For interns, Supervisor's name	20. For interns, Supervisor's VRC ID number	21. For interns, Supervisor's provider #
22. For supervisor or forensic, number of years providing direct vocational services working with Washington industrially injured or ill workers. # of Years: _____ Complete enclosed pertinent work history form.		

B. Vocational Employment Status Form

Page	of	Name	L&I VRC ID Number
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- If you never had a provider number, please enter N/A in the L&I VRC ID number box.
- Otherwise, please provide the following information for provider numbers you currently have with the Department.
- This form is not necessary for first time intern applications, but should be completed if an intern is transferring to a different firm.

Your Provider Number		
Employer	Employer's Provider Number	
I wish to	<input type="checkbox"/> Maintain the above provider number/employer <input type="checkbox"/> Inactivate	Effective Date

Your Provider Number		
Employer	Employer's Provider Number	
I wish to	<input type="checkbox"/> Maintain the above provider number/employer <input type="checkbox"/> Inactivate	Effective Date

Your Provider Number		
Employer	Employer's Provider Number	
I wish to	<input type="checkbox"/> Maintain the above provider number/employer <input type="checkbox"/> Inactivate	Effective Date

Your Provider Number		
Employer	Employer's Provider Number	
I wish to	<input type="checkbox"/> Maintain the above provider number/employer <input type="checkbox"/> Inactivate	Effective Date

Your Provider Number		
Employer	Employer's Provider Number	
I wish to	<input type="checkbox"/> Maintain the above provider number/employer <input type="checkbox"/> Inactivate	Effective Date

C. Vocational Provider Branch Identification Form

Page of	Firm Name	VRC or intern name	
	Provider Number (firm)	VRC ID Number	VRC or intern provider number

List all branches identified by service location (SL) name and number where you will work for this firm.
 The branch listed for interns should **only** be the primary branch address for the vocational firm.

Street address	SL Name	Telephone number
City	SL #	FAX number (if any)

Street address	SL Name	Telephone number
City	SL #	FAX number (if any)

Street address	SL Name	Telephone number
City	SL #	FAX number (if any)

Street address	SL Name	Telephone number
City	SL #	FAX number (if any)

Street address	SL Name	Telephone number
City	SL #	FAX number (if any)

Street address	SL Name	Telephone number
City	SL #	FAX number (if any)

Street address	SL Name	Telephone number
City	SL #	FAX number (if any)

Street address	SL Name	Telephone number
City	SL #	FAX number (if any)

NOTE: Any request to add new branches not previously listed with the vocational firm needs to include the separate Individual Vocational Provider Account Change form (F252-021-000).

D. Pertinent Vocational Work History

Page of	Name	L&I Provider Number	L&I VRC ID Number
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List Your Experience with Industrially Injured Workers Only

- This form is not necessary for intern applications.

Employer			From (Mo/Yr)	To (Mo/Yr)	Total months	Phone #
Address			Supervisor			
City	State	ZIP	Position		Hours worked per week	
Duties						

Employer			From (Mo/Yr)	To (Mo/Yr)	Total months	Phone #
Address			Supervisor			
City	State	ZIP	Position		Hours worked per week	
Duties						

Employer			From (Mo/Yr)	To (Mo/Yr)	Total months	Phone #
Address			Supervisor			
City	State	ZIP	Position		Hours worked per week	
Duties						

Employer			From (Mo/Yr)	To (Mo/Yr)	Total months	Phone #
Address			Supervisor			
City	State	ZIP	Position		Hours worked per week	
Duties						

Employer			From (Mo/Yr)	To (Mo/Yr)	Total months	Phone #
Address			Supervisor			
City	State	ZIP	Position		Hours worked per week	
Duties						

E. Intern Supplemental Application

Note:

- This form is only to be used for intern applicants who were **not** registered with the Department of Labor and Industries prior to December 01, 2000..
- This form reflects amendments to intern qualification requirements in [Chapter 296-19A WAC](#), effective 2-01-04.

Intern Applicant:

Please review the section of [WAC Chapter 296-19A – 210\(4\)](#).

- Based on this review, please complete the following section of this supplemental application, and return this form to the Department along with the rest of your application.
- This *Intern Supplemental Application* must be completed and signed by the applicant, in order to be processed.

Intern Applicant Statement

- I am applying for a Vocational Provider Internship.
- I understand that I am responsible for ascertaining the amount of experience I must obtain in order to satisfy the credential organization eligibility requirements.
- I further understand that the Washington State Department of Labor and Industries will set an internship period based upon my determination, and my representation regarding the credential organization experience requirements and the WAC requirement to obtain experience working with industrially injured or ill workers.
- I further understand that the Department is not responsible or liable for guaranteeing that my experience will be acceptable to the credential organization.
- I understand that it is my responsibility to ensure that the experience I obtain will be acceptable to the credential organization.
- I understand that I must obtain one of the identified credentials within one year of completing my assigned internship, or my provider number(s) will be terminated.

A) Credential that I intend to pursue: CDMS CRC ABVE
B) Current education level: Bachelors Masters Ph.D. None

- I have not been previously registered as an intern with L&I.
- I have been previously registered as an intern with L&I (list intern ID and previous provider numbers).

Date	Printed name	Signature of Intern Applicant
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- Note:**
- All intern applications will be approved for a maximum total of 60 months.
 - Interns can apply for VRC status any time during this 60 month period when they meet the qualifications of [WAC 296-19A-210\(1\)](#).
 - As per [WAC 296-19A-210 \(4b\)](#), interns must obtain one of the VRC certifications within one year of completing their internship.

Statewide Payee Registration for Washington State Department of Labor and Industries

STEP 1: Is this a NEW registration or CHANGE to an existing registration (check one)?

- NEW REGISTRATION** — complete the **ENTIRE** form (STEPS 1 — 6)
- EXISTING REGISTRATION** – complete the **ENTIRE** form (STEPS 1 – 6) and check below what is updated:
- Adding a New Provider Name/DBA Address Contact Information Email Payment Options
- Direct Deposit Additional Information

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

STEP 2: Enter information about the payee and contact person

Legal Name (as shown on your income tax return)	SSN _____ OR EIN _____
Business Name, if different from Legal Name above – e.g. Doing Business As (DBA) Name	Contact Person _____
Payment Address (where payments will be sent)	Contact Telephone Number _____
City, State, and Zip Code	Contact Fax Number _____
Email to receive Statewide Vendor Number and payment notifications	<p style="margin: 0;">For L&I Use Only:</p> <p style="margin: 0;">2350 / MIPS / O /</p> <p style="margin: 0;">L&I # / System / Ownership / L&I Provider #</p>
Type of Business	

STEP 3: Select Payment Option:

- Direct Deposit to bank (recommended) Check in US mail (terminates any previous banking information on file)

If direct deposit is checked, complete STEP 4.

STEP 4: For Direct Deposit, complete all fields below and sign

Financial Institution Name – must be a US institution	Financial Institution Phone Number
Routing Number – see example at right	Account Number – see example at right

In addition to providing your banking information on this form, you may attach a voided check.

Account Type: Checking or Savings (Checking will be used if neither box is marked.)



Authorization for Direct Deposit:

I hereby authorize and request the Consolidated Technology Services (CTS) 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, CTS 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, CTS will notify this office of the error and the reason for the reversal. This authority will continue until such time CTS 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)	Title
SIGNATURE of Authorized Representative	Date

Continue to STEP 5

STEP 5: REQUIRED – Complete and sign the Request for Taxpayer Identification Number (W-9)

Substitute Form W-9	Request for Taxpayer Identification Number and Certification																				
1. Legal Name (as shown on your income tax return)																					
2. Business Name, if different from Legal Name above – eg. Doing Business As (DBA) Name																					
3. Check ONLY ONE box below (see W-9 instructions for additional information)																					
<input type="checkbox"/> Individual or Sole Proprietor <input type="checkbox"/> LLC filing as a sole proprietor <input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation <input type="checkbox"/> S-Corp																				
<input type="checkbox"/> LLC filing as Corporation <input type="checkbox"/> LLC filing as Partnership <input type="checkbox"/> LLC filing as S-Corp	<input type="checkbox"/> Non Profit Organization <input type="checkbox"/> Volunteer <input type="checkbox"/> Board /Committee Member																				
<input type="checkbox"/> Local Government <input type="checkbox"/> State Government <input type="checkbox"/> Federal Government (including tribal)	<input type="checkbox"/> Tax-exempt organization <input type="checkbox"/> Trust/Estate																				
4. For Corporation, S-Corp, Partnership or LLC, check one box below if applicable:																					
<input type="checkbox"/> Medical <input type="checkbox"/> Attorney/Legal																					
5. If exempt from backup withholding, check here: <input type="checkbox"/> (See instructions for W-9 to determine if you are exempt from backup withholding.)																					
6. Address (number, street, and apt. or suite no.)	Department of Labor and Industries Attn: Provider Credentialing and Compliance PO Box 44261 Olympia Wa 98504-4261																				
7. City, State, and ZIP code																					
8. Taxpayer Identification Number (TIN)																					
Enter your EIN <u>OR</u> SSN in the appropriate box to the right (do not enter both) For individuals, this is your social security number (SSN). For other entities, it is your employer identification number (EIN).																					
<i>NOTE: The EIN or SSN must match the Legal Name as reported to the IRS. For a resident alien, sole proprietor, or disregarded entity, or to find out how to get a Taxpayer Identification Number, see the W9 Instructions. If the account is in more than one name, see the W9 Instructions for guidelines on whose number to enter.</i>																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="10" style="text-align: center;">Social security number</td> </tr> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>		Social security number																			
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<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="10" style="text-align: center;">Employer identification number</td> </tr> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>		Employer identification number																			
Employer identification number																					
9. Certification																					
Under penalty of perjury, I certify that:																					
<ul style="list-style-type: none"> • The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and • I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and • I am a U.S. person (including a U.S. resident alien). 																					
<i>(For additional information about the W-9 see the W-9 Instructions.)</i>																					
SIGNATURE of U.S. PERSON	Date																				

STEP 6: Submit to ONE of the following

For Medical Provider
 Provider Account Application & Pay Hold Releases: FAX: 360-902-4484
 Provider Network Application (WPA): FAX: 360-902-4563
 Crime Victims Compensation: FAX: 360-902-5333
Or mail to:
Provider Credentialing & Compliance
PO Box 44261
Olympia, WA 98504-4261

For questions contact Provider Credentialing: 360-902-5140 and select option 4

Instructions for the Statewide Payee Registration Form

The term 'payee' refers to an individual or business that received 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.**

Step 1: Is this a new registration or a change to an existing registration?

Select **NEW REGISTRATION** if:

- You have never completed the Statewide Payee Registration Form.
- You are changing the legal name of a payee already registered.
- You are changing the EIN (Employer Identification Number) or SSN (Social Security Number) of a payee already registered
- You are changing the reporting type (sole proprietor, corporation, etc) on an existing registration.

Select **CHANGE TO EXISTING REGISTRATION** for all other changes to an existing registration, and check the items that have changed. 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 SWV number, please enter it on the form.

Step 2: Payee & contact information

Legal name of payee – enter the name as it appears on federal tax forms.

Business name – “doing business as” name. Enter only if different from legal name.

Payment address – enter the PO Box or street address where you want information sent to you. If you choose to have checks mailed to you, this is the address where they will be sent.

Email for contact person - enter the email address we should use to communicate with you about your registration and your payments. We will use the email address to:

- Notify you when your account has been set up.
- Notify you when changes you submitted have been made.
- Notify you when your payment has been processed, if you have signed up for direct deposit.

Type of business – enter the primary occupation of the payee.

SSN or EIN – enter the SSN or EIN you use with the IRS for the legal name entered.

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.

NOTE: For larger organizations we recommend that you use the email address for a distribution list to ensure that our notifications are received and processed quickly.

Step 3: Payment options

Indicate if you want to receive your payments via Direct Deposit or via US Mail.

