



STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES

PO Box 44322 • Olympia Washington 98504-4322

Dear Provider,

Thank you for your interest in providing services to our workers. Attached you will find the Independent Medical Exam (IME) Provider Account Application. *To receive payment, you must be approved as an IME Provider and be assigned an IME provider account number.*

Practitioners, please submit the following documents:

- Application (2 pages)
- Signed and dated attestation
- Provider agreement (2 pages)
- IME Provider Exam Sites
- Statewide Payee and W-9
- Certificate of successful completion of the *Medical Examiners' Handbook* test
- Current copy of the provider's professional license
- Current copy of the provider's curriculum vitae
- Copy of fellowship certificate(s) if applicable
- Documentation of required Continuing Medical Education (CME) hours if applicable

Firms, please submit the following documents:

- Application (2 pages)
- Certificate of successful completion of the *Medical Examiners' Handbook* test for Quality Assurance staff
- Copy of business license for each exam site location
- IME Provider Exam Site form
- Signed and dated Provider Agreement
- Statewide Payee and W-9

If this is your initial application and you are approved, you will receive:

- Your new provider account number.
- An L&I Toolkit CD which contains:
 - Medical Aid Rules and Fee Schedules.
 - General Billing Manual and forms.
 - Links to publications such as the *Medical Examiners' Handbook*.

If this is your reapplication and you are approved, you will receive notification of your approval.

Additional information about becoming an IME can be found on our website at www.IMEs.Lni.wa.gov.

For more information about:

- State Fund Workers Compensation IME billing and payment questions; contact Provider Hotline at 800-848-0811.
- State Fund and Self Insured Medical Aid Rules and Fee Schedule at:
www.Lni.wa.gov/ClaimsIns/Providers/Billing/default.asp
- Crime Victims IME billing and payment questions; contact Crime Victims at 800-762-3716.
- Crime Victims Compensation Fee Schedule at:
www.Lni.wa.gov/ClaimsIns/Crimevictims/ProvResources/
- IME Tracking System (IMETS): a list of all approved IME examiners and firms is located online at the IME webpage www.IMES.Lni.wa.gov. Select "Find a Medical Examiner." For questions about IMETS, call 360-902-6815.

Sincerely,

Gary Walker, MA, MPA
Provider Credentialing and Compliance

Mail completed applications to:

Department of Labor and Industries
Provider Credentialing and Compliance
PO Box 44322
Olympia WA 98504-4322

IME Provider Account Application

A. Application Information

I am applying as a(n):

- Individual Examiner
 Examiner working with a firm
 Firm

I am working:

- In Washington State
 Outside of Washington State

This application is for:

- New provider/New application
 Current provider – requesting additional provider number
 Current provider – renewal

B. Tax Reporting Information

1. Tax payer identification number (EIN or SSN – must match the W-9 submitted with this application)

C. Payee Account and Billing Information

2. Business name (name used on your bills)	3. Name and phone number of contact person
4. Physical location of business	5. Billing address (where you want your check sent)
Physical address line 2	Billing address line 2
Physical city, state, and zip code	Billing city, state, and zip code
6. Location phone number	7. Billing phone number
9. Medical Director name (Firms only)	10. Medical Director professional license number

D. Practitioner Information

11. Provider's name (Last, First, MI)	12. Gender <input type="checkbox"/> Male or <input type="checkbox"/> Female	13. Date of birth (mm/dd/yyyy)
14. Type of license <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DC <input type="checkbox"/> DDS/DMD <input type="checkbox"/> DPM	15. Professional license number	
16. Practice specialty/subspecialty	17. DEA number and expiration date	
18. Provider's mailing address		
Address line 2		
City, state, and zip code		
19. Provider's phone number	20. Provider's email address	

E. NPI Information

21. Individual provider's name	22. Individual NPI number
23. Organization name	24. Organization's NPI number

Applicant Name: _____

F. Medical Qualifications

1. All applicants must complete the attached Attestation Questionnaire.
2. Attach certification of a passing test score on the *Medical Examiners' Handbook* test.
3. Doctors licensed to perform medicine and surgery (MD), osteopathic medicine and surgery (DO), podiatric medicine and surgery (DPM) must complete the following. Attach a copy of your current dated curriculum vitae, board certification, certification of your specialty, and any verification of fellowship attendance.
 I am certified by a board recognized by:
 American Board of Medical Specialties, name of board(s): _____
 American Osteopathic Assn. Bureau of Osteopathic Specialties, name of board(s): _____
 American Podiatric Medical Association, name of board(s): _____
 I am not board certified
Have you completed a residency? No Yes (Attach documentation)
Are you in the process of completing your Board certification? No Yes - Anticipated completion date: _____
4. Doctors licensed to practice chiropractic must complete the following. Attach a copy of your current dated curriculum vitae and chiropractic license.
 I served as an L&I chiropractic consultant for at least 2 years. Dates: _____
 I attended the department's Chiropractic IME Examiner seminar. New applicants must have attended in the previous 2 years. Date attended: _____
5. Dental examiner applicants must complete the following. Attach a copy of your current dated curriculum vitae and dental license.
 I have a minimum of two years of post-doctoral clinical experience. Dates: _____

G. Practice and Continuing Education Information

1. Do you currently provide patient related services (excluding IMEs)? Yes No
If yes, indicate how many hours (select one reporting method below):
Per week: _____
Per month: _____
Per year: _____
If no, list the date you retired from direct patient care: _____
2. Name of practice, affiliation, or clinic: _____
3. Effective date at primary practice location: _____
4. Contact Name: _____
5. Practice website: _____
6. Additional practice location listed on CV? Yes No
7. Include contact information for additional practice.
8. Do you currently provide a minimum of 768 hours of patient related services per year (16 hours per week)?
 Yes No
If no, you must submit documentation showing you have fulfilled the requirements for your respective state licensure, per WAC 296-23-317 (3). Submit documentation of CE hours indicating name of course, date, and hours earned.

Applicant Name: _____

Labor and Industries IME 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b. Other professional registration or certification in any jurisdiction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	c. Specialty or subspecialty board certification	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	d. Membership on any hospital medical staff	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	e. Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	f. Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national, or international regulatory agency or any public program	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	g. Professional society membership or fellowship	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	h. Participation/member in an HMO, PPO, IPA, PHO or other entity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	i. Academic appointment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	j. Authority to prescribe controlled substances (DEA or other authority)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	a. Do you have notice of any such anticipated charges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b. Are you currently under governmental investigation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. AFFIRMATION OF ABILITIES			
1.	Do you presently use any drugs illegally?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 or professional performance.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement, with or without reasonable accommodation, according to the accepted standards of professional performance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. LITIGATION AND MALPRACTICE COVERAGE HISTORY			
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Have you or an insurance carrier ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Are there any such claims being asserted against you now?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I warrant that all the statements made in 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 application or cause for administrative action.

Practitioner Signature

Date

IME Provider Agreement

The Industrial Insurance Program is authorized by Washington State law, Title 51 Revised Code of Washington (RCW), and is administered by the Department of Labor and Industries. IME services are provided according to Title 51 RCW, Washington Administrative Code (WAC) Chapter 296-23, and policies adopted by the department, including medical coverage decisions.

Issuance of a provider number does not guarantee that all services billed by a provider will be paid by the department. Payments will be made according to the department's Medical Aid Rules and Fee Schedule as updated annually and according to department policy. The department will only reimburse for covered services, provided to injured workers by approved providers.

I (the IME provider), _____, (print or type) agree to and accept all the terms of this agreement and to follow all applicable federal and Washington State statutes, rules and policies. I have enclosed with my application all of the required supporting information to establish an IME provider account, including a current copy of my license and a completed Statewide Payee and W-9. I will provide independent, objective and timely medical opinions for all IMEs I conduct. I understand that it is the expectation of the department that all workers will be treated with dignity and respect. I understand that my performance will be measured by the quality of my examination and report, and not by whether my recommendations are perceived as favorable or unfavorable to the parties involved. I understand that the issuance of an IME provider number by the department does not guarantee that I will receive any IME referrals from the department.

The provider agrees:

1. 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 for injured workers.
2. To comply with Washington State Law Title 51 RCW, Washington Administrative Code (WAC), including but not limited to Chapter 296-23 and policies adopted by the department, including fee schedules and medical coverage decisions. The provider who treats an injured or ill worker who is covered under the department's jurisdiction, accepts the requirements of Title 51 RCW, and the WACs, including but not limited to Chapter 296-20, 296-21, 296-23, and 296-23A, and policies adopted by the department, including fee schedules and medical coverage decisions.
3. 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:
 - a. Services covered by the industrial insurance program which are related to the industrial injury or occupational disease;
 - 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 to the department for consideration in accordance with the instructions contained on the Remittance Advice.

4. To return promptly to the department or self-insurer any excess monies received as payment from the department or self-insurer in error or in excess of the amount properly due under the applicable rules and policies. The department may audit the provider's records to determine compliance with the rules and regulations of the department as provided by Washington State law.
5. 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 by Washington State law.
6. To notify the department immediately of any changes to information in the application or provider status (e.g. any new actions against your professional license, federal tax identification number, ownership, incorporation, address, etc.). A change in ownership or federal tax ID will require a new IME provider account application.

7. If a new IME 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 an IME provider's authorization to provide IME services to injured workers.

Agreement to Code of Ethics

I further agree:

1. To learn and adhere to the standards of ethical conduct as listed in RCW 42.52.140 (Gifts) and RCW 42.52-150 (Limitations on Gifts).
2. To not offer any gift, gratuity, or favor to any department employee to include food and other refreshments.
3. To not seek to unduly influence the actions or decisions of department employees.
4. To report any incidence of unethical conduct or abuse of position by a department employee to the Manager of Provider Credentialing and Compliance, Health Services Analysis, Department of Labor & Industries.
5. To accept that a failure to meet these standards of ethical conduct could result in adverse administrative action by the department and/or criminal actions per RCW 51.48.280 and Title 9A.68.

By signing I accept the terms of this agreement and attest that this application and all the attachments are accurate and true to the best of my knowledge.

Signature

Date

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	For L&I Use Only: 2350 / MIPS / O / L&I # / System / Ownership / L&I Provider #
Type of Business	

STEP 3: Select Payment Option:

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

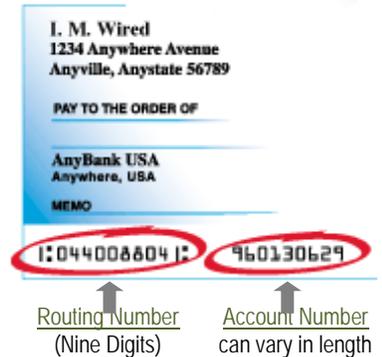
If direct deposit is checked, complete STEP 4.

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="9" 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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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.

