



Submission of Provider Credentials for Interpretive Services

Return completed application to:
 Department of Labor and Industries
 Provider Credentialing and Compliance
 PO Box 44261
 Olympia WA 98504-4261

For interpretive services providers – this form must be submitted in addition to the [Non-Network Provider Application and Statewide Payee and W-9 \(F248-011-000\)](#)

Fax: 360-902-4484
 Questions? Call 360-902-5140

A *separate* form and language certificate is required for each provider.

L&I Provider Number	L&I Group Provider Number
Provider Name	
Primary Phone Number	Alternate Phone Number

Do you want your contact information included on our interpreter look-up website so that workers may locate your business for services in their area?

- Yes No

Check all languages for which you are certified **and** include a copy of certification.

- | | | |
|---|---|--|
| <input type="checkbox"/> American Sign Language (SGN) | <input type="checkbox"/> Japanese (JPN) | <input type="checkbox"/> Serbian – Serb-Croatian (SCC) |
| <input type="checkbox"/> Arabic (ARA) | <input type="checkbox"/> Korean (KOR) | <input type="checkbox"/> Spanish (SPA) |
| <input type="checkbox"/> Bosnian (BOS) | <input type="checkbox"/> Laotian (LAO) | <input type="checkbox"/> Tagalog (TGL) |
| <input type="checkbox"/> Cambodian (KHM) | <input type="checkbox"/> Mandarin Chinese (U01) | <input type="checkbox"/> Vietnamese (VIE) |
| <input type="checkbox"/> Cantonese Chinese (U03) | <input type="checkbox"/> Portuguese (POR) | |
| <input type="checkbox"/> German (GER) | <input type="checkbox"/> Russian (RUS) | |
| <input type="checkbox"/> Others: _____ | | |

Check all Washington state counties where you regularly provide services.

- | | | | |
|-------------------------------------|--|--|---|
| <input type="checkbox"/> Adams-1 | <input type="checkbox"/> Franklin-11 | <input type="checkbox"/> Lewis-21 | <input type="checkbox"/> Snohomish-31 |
| <input type="checkbox"/> Asotin-2 | <input type="checkbox"/> Garfield-12 | <input type="checkbox"/> Lincoln-22 | <input type="checkbox"/> Spokane-32 |
| <input type="checkbox"/> Benton-3 | <input type="checkbox"/> Grant-13 | <input type="checkbox"/> Mason-23 | <input type="checkbox"/> Stevens-33 |
| <input type="checkbox"/> Chelan-4 | <input type="checkbox"/> Grays Harbor-14 | <input type="checkbox"/> Okanogan-24 | <input type="checkbox"/> Thurston-34 |
| <input type="checkbox"/> Clallam-5 | <input type="checkbox"/> Island-15 | <input type="checkbox"/> Pacific-25 | <input type="checkbox"/> Wahkiakum-35 |
| <input type="checkbox"/> Clark-6 | <input type="checkbox"/> Jefferson-16 | <input type="checkbox"/> Pend Oreille-26 | <input type="checkbox"/> Walla Walla-36 |
| <input type="checkbox"/> Columbia-7 | <input type="checkbox"/> King-17 | <input type="checkbox"/> Pierce-27 | <input type="checkbox"/> Whatcom-37 |
| <input type="checkbox"/> Cowlitz-8 | <input type="checkbox"/> Kitsap-18 | <input type="checkbox"/> San Juan-28 | <input type="checkbox"/> Whitman-38 |
| <input type="checkbox"/> Douglas-9 | <input type="checkbox"/> Kittitas-19 | <input type="checkbox"/> Skagit-29 | <input type="checkbox"/> Yakima-39 |
| <input type="checkbox"/> Ferry-10 | <input type="checkbox"/> Klickitat-20 | <input type="checkbox"/> Skamania-30 | |

Check all out of state areas where you regularly provide services.

- California Idaho Oregon Other: _____

Instructions for Credential Submission Form

For interpretive services providers, this form is submitted in addition to the [Non-Network Provider Application and Statewide Payee Registration and W-9](#). See the credentialing standards listed below. Complete the provider account information; mark the language(s) for which you hold credentials; and the geographic area(s) where you regularly provide services.

Credentialing Standards

Agency or Organization	Credential
Certified Interpreter – Interpreter who holds credentials in good standing from one or more of the following:	
Washington State Department of Social and Health Services	Social or Medical Certificate
Washington State Administrative Office for the Courts	Certificate
RID-NAD National Interpreter Certification (NIC)	Certified Advanced (Level 2) Certified Expert (Level 3)
Registry of Interpreters for the Deaf (RID)	Comprehensive Skills Certificate (CSC) Master Comprehensive Skills Certificate (MCSC) Certified Deaf Interpreter (CDI) Specialist Certificate: Legal (SC:L) Certificate of Interpretation and Certificate of Transliteration (CI/CT)
National Association for the Deaf (NAD)	Level 4 Level 5
Federal Court Interpreter Certification test (FCICE)	Certificate
US State Department Office of Language Services	Verification letter or Certificate
Qualified Interpreter – Interpreter who holds credentials in good standing from one or more of the following:	
Translators and Interpreters Guild	Certificate
Washington State Department of Social and Health Services	Letter of authorization as qualified social and/or medical services interpreter
Federal Court Interpreter Certification (FCICE)	Letter of designation or authorization
Certified Translator – Translator who holds credentials in good standing from one or more of the following:	
Washington State Department of Social and Health Services	Translator Certificate
Translators and Interpreters Guild	Certificate
American Translator Association	Certificate

Qualified Translator

Translator who has passed a written language fluency examination in both English and in the other tested language(s). The test must be administered by a state agency; a state or federal court system; other organization including language agencies; and/or accredited academic institution of higher education. Translators must have a minimum of two years' experience in document translation.

Credentials from other organizations or states

Interpreters and translators located outside of Washington State must submit certification or qualification from their state Medicaid programs; state or federal court system; or other nationally recognized programs. For interpreters from any geographic area, credentials submitted from agencies or organizations other than those listed above, may be accepted in the testing criteria can be verified as meeting the minimum standards listed below:

<p>Interpreter test(s) consists of, at minimum:</p> <ul style="list-style-type: none"> • A written test in English, and • A verbal of sight translation in both English and other tested language(s), and • A verbal test of consecutive interpretation in both languages, and • For those providing services in a legal setting, a verbal of simultaneous interpretation in both languages. 	<p>Translator test consists of, at minimum:</p> <ul style="list-style-type: none"> • A written test in English and in the other language(s) tested; or • A written test and work samples demonstrating the ability to translate from one specific source language to another specific target language.
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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 treating Washington's injured workers and crime victims. This application is for providers who are:

- Excluded from the L&I Medical Provider Network.
- Treating crime victims.
- Only treating injured workers for their initial visit.

If you would like to learn more information about the Provider Network, including the types of providers who must join the network to provide ongoing care, please visit: www.JoinTheNetwork.Lni.wa.gov.

To become a non-network provider, you will need to submit:

- A completed application. If you are a member of group, each provider will need to submit an application.
- A signed copy of the Provider Agreement page.
- A completed Statewide Payee Registration and W-9 form (attached).
- A copy of your license or certification as required by your state health regulations.

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. You will also receive an L&I Toolkit CD that has information and links to our website about treating injured workers and billing the department.

We offer electronic billing for providers billing State Fund. 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 the application, please contact us at 360-902-5140.

Thank you,

Provider Credentialing

Application Instructions

Complete the application using 12 point font or clearly print using dark ink.

A. Tax payer information

1. Tax Identification number or Social Security Number you will use when billing L&I.
2. L&I group number – if you are member of previously established L&I group.

B. Account & Billing information

3. Business name that you will use when billing L&I.
4. Name and phone number of the person we can call if we have questions about this application.
5. Physical address of your business. This can't be a P.O. Box.
6. Billing address – where you want your payments mailed.
7. Location phone number – where we can contact you to schedule services.
8. Billing phone number – where we can contact you about billing questions.

C. Individual provider or organization information

9. Provider's name in last, first name format or organization name.
10. Type of service(s) you provide.

Complete steps 11 – 18 if applicable to your provider type.

11. Your professional license number. Attach a copy of your license to your application.
12. The date your license was issued in the month, day, and year format.
13. The date your license will expire in the month, day, year format.
14. The state where your license was issued.
15. Physical Medicine & Rehabilitation only – your board certification number.
16. Pharmacy only – your NCPDP or NABP number.
17. Enter your DEA number (if applicable) and expiration date. Attach a copy to your application.
18. Physician Assistants only – your supervising physician name and L&I provider number.

D. NPI information

19. Your name.
20. Your individual NPI number.
21. Your organization's name.
22. Your organization's name.

E. Provider agreement

23. Read, initial each section, and sign. You must sign the agreement for an account to be set up. Please read this carefully.

F. Find-A-Doc

24. Select yes or no. If no selection is made, you will be listed on the website. If you are only treating for the initial visit or have provisional status in the network, you will not be listed on the website.

G. Provider specialty

25. Mark the box next to your provider type and specialty. Include copies of license/certification as indicated.
26. Optional – any additional specialized information.

Non-Network Provider Application

Mail or fax completed applications to:

Provider Credentialing & Compliance
 PO Box 44261
 Olympia WA 98504-4161

Fax: 360-902-4484

- Complete the application using 12 point font or dark ink.
- Questions? Call 360-902-5140.

A. Tax Payer Information

1. Tax payer identification number (EIN or SSN)	2. L&I provider group number (if applicable)
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B. Account and Billing Information

Check if you want all your mail to go to the billing address provided below. Otherwise, claim-related mail will be sent to your physical location.

3. Business name (name used on your bills)	4. Name and phone number of contact person
5. Physical location of business	6. 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
7. Location phone number	8. Billing phone number

C. Individual Provider or Organization Information – Attach copies of your medical license or certification and your DEA permit.

9. Provider's name (Last, First, MI)		10. Provider specialty/Services provided	
11. Professional license number	12. License issue date	13. License expiration date	14. State where issued
15. Physical medicine & rehabilitation only – Board certified? Include copy of certification. <input type="checkbox"/> Yes <input type="checkbox"/> No		16. Pharmacies - NCPDC or NABP	17. DEA number & expiration date
18. Physician assistants only – Supervisory physician's name and L&I provider account number.			

D. NPI information

19. Individual provider's name	20. Individual NPI number
21. Organization name	22. Organization's NPI

E. Provider Agreement

Initial each section and sign at the bottom of the page.

23. 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); federal tax information changes; 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, and a completed Statewide Payee Registration and W-9.

Title

Signature

Date

F. Find-A-Doc (FAD) Website

24. Do you want your contact information included on the Find-A-Doc websites so that workers or crime victims may locate your business for services in their area?

Workers (State Fund)

Yes No

www.Lni.wa.gov/ClaimsIns/Claims/FindADoc/

Crime Victims

Yes No

www.Lni.wa.gov/ClaimsIns/CrimeVictims/FindADoc/

G. Provider Specialty Information

25. Check the provider types and/or specialty services you provide.

- Ambulatory surgery centers – include copies your state license; Medicare certification or accreditation by JCAHO, AAAHC, or AAAASF.
- Interpreters – include the Submission of Provider Credentials for Interpreter Service (F245-055-000) and a copy of your certification.
- Lab facilities – include copies of Clinical Laboratory Improvement Amendments (CLIA).
- RNFA – include copies of you privilege letter for each facility you work from.
- Pain clinics – include copies of your Commission on Accreditation of Rehabilitation Facilities (CARF).
- Pharmacy – include copies of your DEA permit; pharmacy license; and NCPDP or NABP number.
- Physical medicine & rehabilitation physicians – include copies of your certification.
- Schools – include your accreditation and business license.

<input type="checkbox"/> Adult Family Home	<input type="checkbox"/> Nurse	<input type="checkbox"/> Physician assistant (certified)
<input type="checkbox"/> Ambulance	<input type="checkbox"/> ARNP	<input type="checkbox"/> Podiatrist
<input type="checkbox"/> Ambulatory surgery center	<input type="checkbox"/> ARNP – Psychiatric	<input type="checkbox"/> Prosthetist/Orthotist
<input type="checkbox"/> Audiologist	<input type="checkbox"/> CRNA	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> NCM	<input type="checkbox"/> Radiology – technical component
<input type="checkbox"/> Day care provider (licensed)	<input type="checkbox"/> RN	<input type="checkbox"/> Registered dietician
<input type="checkbox"/> Dentist	<input type="checkbox"/> RNFA	<input type="checkbox"/> Respiratory therapy
<input type="checkbox"/> Denturist	<input type="checkbox"/> Nursing home	<input type="checkbox"/> School
<input type="checkbox"/> Oral surgery	<input type="checkbox"/> Naturopathic physician	<input type="checkbox"/> Skilled nursing facility
<input type="checkbox"/> Orthodontia	<input type="checkbox"/> Occupational therapist	<input type="checkbox"/> Speech pathologist
<input type="checkbox"/> DME supplier	<input type="checkbox"/> Work hardening	<input type="checkbox"/> Tape intermediary
<input type="checkbox"/> Drug & alcohol treatment facility	<input type="checkbox"/> Optician	<input type="checkbox"/> Transportation
<input type="checkbox"/> Fitter/dispenser	<input type="checkbox"/> Optometrist	<input type="checkbox"/> Other
<input type="checkbox"/> Home health agency	<input type="checkbox"/> Osteopathic physician	<input type="checkbox"/> Job mod/pre-job mod supplier
<input type="checkbox"/> IV therapy	<input type="checkbox"/> Pain clinic	<input type="checkbox"/> Job mod/pre-job mod consultant
<input type="checkbox"/> Home care	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> On-the-job training
<input type="checkbox"/> Hospital	<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Lodging
<input type="checkbox"/> Hospital psychiatric	<input type="checkbox"/> Work hardening	<input type="checkbox"/> Home modification
<input type="checkbox"/> Hospital outpatient	<input type="checkbox"/> Hand therapy	<input type="checkbox"/> Vehicle modification
<input type="checkbox"/> Interpreter	<input type="checkbox"/> Physician	<input type="checkbox"/> Investigative services
<input type="checkbox"/> Lab facilities	<input type="checkbox"/> PM&R	
<input type="checkbox"/> Licensed Massage Practitioner		

26. Other specialized information:

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)

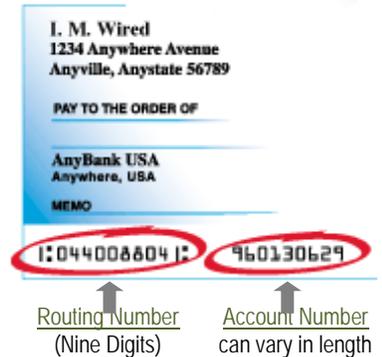
If direct deposit is checked, complete STEP 4.

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="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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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.

