Add Group Packet

Network Provider Account and Credentialing

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

Fax: 360-902-4563

When adding a participating network provider to your group, please submit the following required documents:

- Pages 1 and 2 of the Washington State Practitioner Application (WPA)
- IRS Form W-9 (the Tax ID on Page 2 of the WPA must match the Tax ID on the IRS Form W-9)
- 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
- Avoid the following so we can process your application
  - Missing information
  - Stamped signatures

Required step:

- 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
  - OFM's forms can be found at: ofm.wa.gov/it-systems/accounting-systems/statewide-vendorpayee-services

The OFM forms must be completed concurrently with the submission of this application to avoid potential delays in payment.

For questions regarding OFM's Forms or registration process call 360-407-8180 or email: payeeRegistration@ofm.wa.gov

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.

Questions? Email your questions to provnet@Lni.wa.gov

Where to find forms: Go to lni.wa.gov/patient-care/provider-accounts/become-a-provider/

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

- **Keep an unsigned and undated 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. *Please do not use abbreviations*. **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:	Zip Code:	
Home Telephone Number: ( )	Pager Number: ( )	Cell Phone Number: ( )	E-Mail 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

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