

# STATE OF WASHINGTON DEPARTMENT OF HEALTH CLIENT SERVICES PROVIDER CONTRACT

**PROVIDER CONTRACT #: N18154****Instructions for completing and returning your agreement:**

- Complete both copies of provider agreement and Appendix A in **BLUE** ink and return along with a current copy of your W-9 and State wide Payee Registration form. All sections must be completed. When your agreement is finalized by our contracts department you will receive a signed copy of the contract in the mail.

**RETURN THIS AGREEMENT TO:** Washington State Department of Health,  
HIV Client Services, Early Intervention Program  
P.O. Box 47841  
Olympia WA 98504-7841

**PROFESSIONAL MEDICAL/LABORATORY/RADIOLOGY/DENTAL/MENTAL HEALTH SERVICES AND CHEMICAL TREATMENT AGREEMENT BETWEEN THE STATE OF WASHINGTON DEPARTMENT OF HEALTH, EARLY INTERVENTION PROGRAM AND: PRACTITIONER / CLINIC INFORMATION****PRACTITIONER / CLINIC INFORMATION**

1. Legal name of provider (Last, first, middle initial followed by credentials):
2. Date of Birth (*if individual provider*):
3. Doing business as (DBA):
4. Federal Tax ID#:
5. Uniform Business Identifier (UBI)#:

*NOTE: If signing this agreement as a clinic, provide the clinic's name and IRS Tax ID number and list individual provider names and birthdates on the attached sheet. If signing this agreement as an individual provider, list the IRS Tax ID number issued to you individually.*

6. Business Mailing Address:
7. Business Telephone #:
8. Licensed Provider?  Yes  No  
License Number: \_\_\_\_\_
9. Provider Profession (please check one):  
 Medical  Laboratory  Radiologists  Ophthalmologist  Dental  Mental Health  Chemical Dependency

Specialty (if applicable): \_\_\_\_\_ Limitations (if applicable): \_\_\_\_\_

This Agreement is made between the State of Washington Department of Health, HIV Client Services, Early Intervention Program hereinafter known as the "DEPARTMENT" and the medical provider named above, and hereinafter known as the "PROVIDER" and if applicable, supersedes and cancels the previous agreements under *Contract Number 2635, N09727, N15264, N16754 or N17455*. The purpose of this Agreement is to provide certain HIV early intervention medical care services by licensed providers to persons enrolled in the Early Intervention Program, and to provide the DEPARTMENT with clinical information on enrolled clients as requested.

**TERMS AND CONDITIONS**

This Agreement shall commence upon the first day of month of final date of signature by the DEPARTMENT contract officer and continue for five years from that date or earlier if terminated under this Agreement's termination for default or convenience provisions.

DO NOT WRITE BELOW THIS LINE – DEPARTMENT OF HEALTH USE ONLY

Practitioner/Clinic Name:

Provider ID #:

**Payment**

- (1) The DEPARTMENT shall make no payment to the PROVIDER under this Agreement for services provided to enrolled clients prior to the execution of this Agreement.
- (2) Payment shall be in accordance with the fees published by the DEPARTMENT in the EARLY INTERVENTION PROGRAM SCHEDULE OF COVERAGE AND MAXIMUM ALLOWANCES or the PROVIDER'S usual and customary fees, whichever is less.
- (3) The DEPARTMENT shall make no payment in advance or in anticipation of services.
- (4) The DEPARTMENT is the payer of last resort. The PROVIDER shall seek reimbursement from all other third party payers before seeking reimbursement from the DEPARTMENT.
- (5) The PROVIDER may not bill, demand, collect or accept payment for a service covered under this agreement from a client or anyone on the client's behalf, other than the DEPARTMENT or third party payer. The PROVIDER agrees not to "Balance Bill" the client for these covered services. PROVIDER may not bill a client "interest" charges while waiting for payment from the DEPARTMENT.
- (6) The PROVIDER shall submit all billings within 9 months from date of service. The DEPARTMENT shall not be obligated to pay for services if the billing is not received within 180 days of service provision. Nor may PROVIDER bill the client for these services.
- (7) All billings to the DEPARTMENT shall identify the PROVIDER Name, IRS Tax ID number, and DEPARTMENT assigned provider number which shall be identical to those listed in this Agreement. Changes to any of the above stated forms of identity must be reported on an updated W-9 form and State Wide Payee form within 30 days for payment to be issued. The assigned provider ID number **MUST** be entered on the claim form to be considered for payment.
- (8) The DEPARTMENT may deny payment for covered services if the PROVIDER fails to satisfy the conditions of payment outlined in this Agreement. In such instances, the PROVIDER shall not bill the client. PROVIDER may not bill the client while waiting for a response from the DEPARTMENT or services that are denied due to PROVIDER'S failure to receive prior approval for services when necessary.

**Assignment**

Neither this Agreement nor any claim arising under this Agreement, shall be transferred or assigned by the PROVIDER without prior written consent of the DEPARTMENT.

**Indemnification**

The PROVIDER shall defend, protect and hold harmless the State of Washington, the DEPARTMENT, or any employee thereof, from and against all claims, suits, or actions arising from negligent acts or omissions of the PROVIDER, employees, its agents, or subcontractors while performing under the terms of this agreement and to hold the State of Washington harmless from any expenses connected with the defense, settlement, or payment or monetary judgment from such claims, suits or actions, and duties in performance of the Agreement.

**Licensing, Accreditation and Registration**

The PROVIDER shall comply with all applicable local, state, and federal licensing, accreditation and registration requirements/standards, necessary for the performance of this Agreement. The PROVIDER'S license shall be current and unrestricted with regard to practice.

DO NOT WRITE BELOW THIS LINE – DEPARTMENT OF HEALTH USE ONLY

Practitioner/Clinic Name: \_\_\_\_\_ Provider ID #: \_\_\_\_\_

**Nondiscrimination**

The PROVIDER shall, during the performance of this contract, comply with the Americans with Disability Act (42 U.S.C. Section 12101 et seq.) Washington State Law against Discrimination, Chapter 49.60 RCW, and shall not Discriminate on the grounds of race, color, sex, sexual orientation, religion, national origin, alien status, marital status, age, creed, Vietnam-era or disabled veterans status, or the presence of any sensory, mental or physical handicap. The PROVIDER shall not: 1) deny an individual any services or other benefits provided under this Agreement; 2) provide any service(s) or other benefits to an individual which are different, or are provided in a different manner from those provided to others under this Agreement, or 3) subject an individual to segregation or separate treatment in any manner related to the receipt of any service(s) or other benefits provided under this Agreement.

**Overpayments**

In the event that the DEPARTMENT overpays or makes erroneous payments to the PROVIDER under this agreement, the PROVIDER shall repay the DEPARTMENT promptly. The DEPARTMENT will either secure repayment by a set-off against the next month's billing or request reimbursement from the PROVIDER.

**Right of Inspection**

The PROVIDER shall provide right of access to its facilities to the DEPARTMENT, or any of its officers, or to any other authorized agent or official of the state of Washington or the federal government, at all reasonable times, in order to monitor and evaluate performance, compliance, and/or quality assurance under this Agreement.

**Safeguarding of Client Information**

The use or disclosure by any party of any information concerning a patient for any purpose not directly connected with the administration of the DEPARTMENT'S or the PROVIDER'S responsibilities with respect to services provided under this Agreement is prohibited except by written consent of the recipient or patient, his/her attorney, or his/her responsible parent or guardian, or as provided by Washington state law.

**Savings**

In the event funding from state, federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of the Agreement and prior to normal completion, either party may terminate the Agreement under the "Termination for Convenience" clause.

**Emergency Preparedness**

Emergency messages may be distributed to Service Organizations via email distribution lists, postings to the HIV Client Services Website, phone calls and teleconferences.

DO NOT WRITE BELOW THIS LINE – DEPARTMENT OF HEALTH USE ONLY

Practitioner/Clinic Name: \_\_\_\_\_ Provider ID #: \_\_\_\_\_

**Termination for default**

In the event DEPARTMENT determines the PROVIDER has failed to comply with the conditions of this contract in a timely manner, DEPARTMENT has the right to suspend or terminate this contract. Further, DEPARTMENT may terminate this contract for default, in whole or in part, if DEPARTMENT has a reasonable basis to believe that the PROVIDER has:

- a) Failed to meet or maintain any requirement for contracting with DOH;
- b) Failed to ensure the health or safety of any client for whom services are being provided under this contract;
- c) Failed to perform under, or otherwise breached, any term or condition of this contract; and/or
- d) Violated any applicable law or regulation.

Before suspending or terminating the contract, DEPARTMENT shall notify the PROVIDER in writing of the need to take corrective action. If corrective action is not taken within thirty (30) days, the contract may be terminated or suspended. DEPARTMENT reserves the right to suspend all or part of the contract, withhold further payments, or prohibit the PROVIDER from incurring additional obligations of funds during investigation of the alleged compliance breach and pending corrective action by the PROVIDER or a decision by DEPARTMENT to terminate the contract.

**Termination for Convenience**

Except as otherwise provided in this Agreement, either party may, by fourteen (14) days written notice, terminate this contract in whole or in part when it is in the best interest of either party. If the contract is so terminated, either party shall be liable only for payment in accordance with the terms of this contract for services prior to the effective date of termination..

**All Writings Contained Herein**

This Agreement contains all the items and conditions agreed upon by the parties. No other understanding, oral or otherwise regarding the subject matter of this Agreement shall exist or bind any of the parties hereto. The parties to this Agreement agree to abide by and fully comply with the provisions set forth herein. I understand and acknowledge that the DEPARTMENT will investigate the information in this agreement. By submitting the agreement, I agree to such investigation and to information exchange activities of the DEPARTMENT as a part of the verification and credentialing process.

Medical/Dental/Lab/Mental Health Provider

Date

Department of Health Contracts Officer

Date

Date Effective

Until

Reviewed by Client Services Staff  
(Approved as to form by Assistant Attorney General)

Date

DO NOT WRITE BELOW THIS LINE – DEPARTMENT OF HEALTH USE ONLY

Practitioner/Clinic Name: \_\_\_\_\_ Provider ID #: \_\_\_\_\_



PLEASE  
DO NOT  
STAPLE

# Statewide Payee Registration Washington State

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

NEW REGISTRATION

CHANGE to EXISTING REGISTRATION – complete the ENTIRE form and check below what is updated:

Name/DBA    Address    Contact Information    Email    Payment Options    Direct Deposit    Additional Information

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

### STEP 2: Enter information about the payee and contact person

Legal Name of Payee as it appears on federal tax forms (see W-9)

Business Name, if different from Legal Name above – e.g. Doing Business As (DBA) Name

Mailing Address

City, ST and Zip Code

Email to receive Statewide Vendor Number and payment notifications

Type of Business

SSN	OR	EIN
Contact Person		
( )	-	Ext.
Contact Telephone Number		
( )	-	
Contact Fax Number		
3030	/ RWCS	/ 0
DOH# / System / Ownership		

### STEP 3: Select Payment Option:

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

### 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 also 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 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

<b>STEP 5: Complete and sign the Request for Taxpayer Identification Number (W-9)</b>	
Substitute Form <b>W-9</b>	<b>Request for Taxpayer Identification Number and Certification</b>
<b>1. Legal Name</b> (as shown on your income tax return)	
<b>2. Business Name</b> , if different from Legal Name above – e.g. Doing Business As (DBA) Name	
<b>3. Check ONLY ONE box below</b> (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
<b>4. For Corporation, S-Corp, Partnership or LLC, check one box below if applicable:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Attorney/Legal	
<b>5. If exempt from backup withholding, check here:</b> <input type="checkbox"/> (See Instructions for W-9 to determine if you are exempt from backup withholding)	
<b>6. Address</b> (number, street, and apt. or suite no.)	<b>For office use</b>
<b>7. City, state, and ZIP code</b>	The Legal Name, Address and TIN must be filled in completely and the document signed for the forms to be accepted.
<b>8. Taxpayer Identification Number (TIN)</b>	
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).	
<div style="border: 1px solid black; padding: 5px; text-align: center; color: blue; font-style: italic;">Social security number</div>	
<b>OR</b>	
<div style="border: 1px solid black; padding: 5px; text-align: center; color: blue; font-style: italic;">Employer identification number</div>	
<p><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></p>	
<b>9. Certification</b>	
Under penalty of perjury, I certify that:	
<ul style="list-style-type: none"> <li>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</li> <li>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</li> <li>I am a U.S. person (including a U.S. resident alien).</li> </ul>	
<b>SIGNATURE of U.S. PERSON</b>	Date

**STEP 6: Submit to ONE of the Following:**

**For Fastest Service, PRINT, SIGN, SCAN and EMAIL to: [eip.claimspayment@doh.wa.gov](mailto:eip.claimspayment@doh.wa.gov)**

If you do not have scanning ability, you may fax to **(360) 664-2216**  
 Or Mail to: **Washington State Department of Health, Client Services**  
**PO Box 47841 Olympia, WA 98504-7841**