



<b>SECTION 2 - Payee type (Please select the primary payee type)</b>		
<b>Medical</b>		<b>Miscellaneous</b>
<b>Agencies</b>	<b>Hospitals</b>	
<input type="checkbox"/> Community/Behavioral Health	<input type="checkbox"/> Hospital	<input type="checkbox"/> Agency
<input type="checkbox"/> Home Health	<b>Laboratories</b>	<input type="checkbox"/> Attorney
<input type="checkbox"/> Hospice Care	<input type="checkbox"/> Clinic Medical Laboratory	<input type="checkbox"/> Clerk of Court
<input type="checkbox"/> In Home Supportive Care	<input type="checkbox"/> Physiological Laboratory (IDTF)	<input type="checkbox"/> Collection Agency
<b>Ambulatory Health Care Facilities</b>	<b>Nursing &amp; Custodial Facilities</b>	<input type="checkbox"/> Court Reporter
<input type="checkbox"/> Ambulatory Surgical Center	<input type="checkbox"/> Nursing & Custodial Care Facility	<input type="checkbox"/> Funeral Home
<input type="checkbox"/> Chiropractic Clinic	<b>Other Service Providers</b>	<input type="checkbox"/> Insurance Company
<input type="checkbox"/> Clinic/Center	<input type="checkbox"/> Lodging	<input type="checkbox"/> Moving/Van Line
<input type="checkbox"/> Dental Clinic	<b>Suppliers</b>	<input type="checkbox"/> Physical Fitness Program
<input type="checkbox"/> Hearing and Speech Clinic	<input type="checkbox"/> DME & Medical Supplies	<input type="checkbox"/> Private Investigator
<input type="checkbox"/> Massage Therapy Clinic	<input type="checkbox"/> Hearing Aid Equipment	<input type="checkbox"/> Records Copying Service
<input type="checkbox"/> Mental Health Clinic	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Retail Service
<input type="checkbox"/> Optometry Clinic	<input type="checkbox"/> Prosthetic/Orthotic Supplier	<input type="checkbox"/> School
<input type="checkbox"/> Physical Therapy Clinic	<b>Transportation Services</b>	<input type="checkbox"/> Sheriff
<input type="checkbox"/> Podiatric Clinic	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Travel Agency
<input type="checkbox"/> Radiology/MRI Center	<input type="checkbox"/> Bus/Taxi	<input type="checkbox"/> Other

<b>SECTION 3 - Sign up for medical provider electronic communications</b>	
If you would like to receive WSI provider news communications by e-mail, sign up below.	
Contact Name	E-Mail Address

<b>SECTION 4 - Submission of form</b>
Return completed form (both pages) to:
<p>Workforce Safety &amp; Insurance            PO Box 5585            Bismarck ND 58506-5585</p> <p>Fax 701-328-3820</p> <p>Email <a href="mailto:ndwsi@nd.gov">ndwsi@nd.gov</a></p> <p>For questions, contact WSI Customer Service 1-800-777-5033 or 701-328-3800</p>

## Payee Registration Substitute IRS Form W9 Instructions

### Purpose of Form

The State of North Dakota is required to obtain your correct taxpayer identification number (TIN) to file an information return with the IRS. Do not send these instructions with your completed form.

### SECTION 1 Request for taxpayer identification number information

#### Legal name

Individuals: Fill in the name as shown on your income tax return.

Businesses: Fill in the name as shown on your business IRS filing.

#### Doing Business As (DBA)

Individuals: Leave blank

Businesses: If your firm operates under another name state it here.

#### Business National Provider Identifier (NPI) number

Enter NPI of business as registered with National Plan & Provider Enumeration System (NPPES).

#### Taxpayer identification number

Individuals: Enter the social security number (SSN) that matches the legal name.

Sole Proprietor: Enter the social security number (SSN) or Employer identification number that matches the legal name.

All Other Businesses: Enter the Employer identification number that matches the legal name.

#### Tax classification

Check the IRS tax classification box that matches the legal name entered on this form.

#### Remittance address

Enter the address where payments should be sent.

#### Physical location address

Enter the physical address where services are rendered.

#### Correspondence Address

Enter the address where correspondence should be sent.

#### Contact Information:

Enter the contact person for information provided on this form.

#### Affidavit

Please read the affidavit thoroughly. This paragraph explains what your signature authorizes.

#### Certification

This certification is copied from the IRS Form W9. Check the following website for verification and further clarification:

<http://www.irs.gov/pub/irs-pdf/fw9.pdf>

#### Signature of authorizing agent

Establishes that you are a U.S. person, or resident alien with authority to make changes as designated on this form for this bidder profile. This application will be rejected if not authenticated accordingly.

### SECTION 2 Payee type

Identify the type of business, i.e. medical or miscellaneous. If medical, select all applicable types.

### SECTION 3 Sign up for medical provider electronic communications

Indicate your consent to receive electronic communication and provide contact information.

### SECTION 4 Submission of form

Return completed form (both pages) to:

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PO Box 5585  
Bismarck ND 58506-5585

Fax 701.328.3820

Email [ndwsi@nd.gov](mailto:ndwsi@nd.gov)