MEDICAL PROVIDER PAYEE REGISTRATION

MEDICAL SERVICES DIVISION
SFN 53043 (03/2023)

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Bismarck ND 58506-5585
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WSI Internal use only

SECTION 1 – *Practice group/billing NPI information*

Complete this registration form for each unique group/billing National Provider Identifier (NPI) used to bill Workforce Safety & Insurance (WSI). For a practice with multiple group/billing NPIs, complete a separate registration form for each group/billing NPI.

The group/billing NPI submitted below should match the NPI reported in Box 33a of the CMS 1500, Box 56 of the UB-04, or in the corresponding fields for electronic billing.

Practice legal name (name as registered on IRS W9)

Practice pay to name (if different from legal name above)

Practice TIN/SSN*

Practice group/billing NPI

Tax classification
☐ Corporation ☐ Partnership ☐ Individual/sole proprietor ☐ Disregarded entity ☐ Other

Practice payment address (address where WSI sends payment)

Address	City	State	ZIP code
Telephone number	Fax number		

SECTION 2 – *Practice location information*

Complete this section to indicate the primary practice, physical, and correspondence addresses. WSI relies on this information to correspond with the practice and individual providers associated with the practice.

Primary practice name and physical address (address where practice is located; PO Box is not allowed)

Name

Address	City	State	ZIP code
Telephone number	Fax number		

Primary practice correspondence address (address where WSI sends correspondence regarding medical treatment)

Same as ☐ Payment address ☐ Primary practice physical address

Address	City	State	ZIP code

SECTION 3 – *Medical records request information*

Complete this section to indicate where WSI should send a request for a medical record. This information applies to the primary practice location and any additional service locations listed as part of this application in Section 4.

Same as ☐ Payment address ☐ Primary practice physical address ☐ Primary practice correspondence address

Address	City	State	ZIP code
Telephone number	Fax number		

SECTION 4 – *Additional service location information (for a practice with only 1 location, proceed directly to Section 5)*

Additional service location name and physical address (address where practice is located; PO Box is not allowed)

Name			
Address	City	State	ZIP code
Telephone number	Fax number		

Additional service location correspondence address (address where WSI sends correspondence regarding medical treatment)

Same as ☐ Payment address ☐ Physical address above ☐ Primary practice correspondence address

Address	City	State	ZIP code

Additional service location name and physical address (address where practice is located; PO Box is not allowed)

Name			
Address	City	State	ZIP code
Telephone number	Fax number		

Additional service location correspondence address (address where WSI sends correspondence regarding medical treatment)

Same as ☐ Payment address ☐ Physical address above ☐ Primary practice correspondence address

☐ Same as physical address above

Address	City	State	ZIP code

Additional service location name and physical address (address where practice is located; PO Box is not allowed)

Name			
Address	City	State	ZIP code
Telephone number	Fax number		

Additional service location correspondence address (address where WSI sends correspondence regarding medical treatment)

Same as ☐ Payment address ☐ Physical address above ☐ Primary practice correspondence address

☐ Same as physical address above

Address	City	State	ZIP code

Additional service location name and physical address (address where practice is located; PO Box is not allowed)

Name			
Address	City	State	ZIP code
Telephone number	Fax number		

Additional service location correspondence address (address where WSI sends correspondence regarding medical treatment)

Same as ☐ Payment address ☐ Physical address above ☐ Primary practice correspondence address

☐ Same as physical address above

Address	City	State	ZIP code

SECTION 5 – *Medical Provider News sign-up*	
Complete this section if you would like to receive Medical Provider News (including agency, billing, pharmacy, and utilization review news). You may also sign up online under Medical Provider News at www.workforcesafety.com.	
Name	Email address

SECTION 6 – *Signature*	
Affidavit By completing, signing, and filing this form, I certify the information above is current and true to the best of my knowledge and is no way misleading. I ensure any change of information will be forwarded to WSI.	
Certification Under penalties of perjury, I certify that: (1) The number shown on this form is my correct taxpayer identification number; and (2) 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 (3) I am a U.S. person (including a U.S. resident alien).	
Name	Email address
Telephone number	Fax number
Signature	**Date**

* In compliance with the Federal Privacy Act of 1974, disclosure of the Social Security number on this form is mandatory pursuant to N.D.C.C. § 65-05-02. The Social Security number is used for identification and verification purposes. Failure to provide this information may result in a delay in processing your request.