North Dakota Workforce Safety & Insurance

# PAYEE REGISTRATION & SUBSTITUTE IRS FORM W9

FINANCE DIVISION
SFN 53043 (08/2014)

1600 EAST CENTURY AVENUE, SUITE 1
PO BOX 5585
BISMARCK ND 58506-5585
**Telephone 1-800-777-5033**
Toll Free Fax 1-888-786-8695
TTY (hearing impaired) 1-800-366-6888
Fraud and Safety Hotline 1-800-243-3331
www.WorkforceSafety.com

| ☐ **New registration** (includes changes to legal name, taxpayer identification number, social security number)<br>☐ **Change to existing registration** (complete parts of the form relevant to the change) | ***WSI claim number***<br>***Internal use only*** |
|---|---|

## SECTION 1 - *Request for taxpayer identification number information*

Legal name (exact name as filed with IRS or SSA; any variation in name or TIN will cause a delay in processing)

| Doing Business As (DBA) (information must match billing statement; medical provider information must match CMS 1500 box 33 or UB 04 box 2) | Business National Provider Identifier (NPI) number (medical provider only) |
|---|---|

Taxpayer identification number (TIN) - **Provide only one**

Employer identification number: ☐☐-☐☐☐☐☐☐☐

**Or**

Social security number: ☐☐☐-☐☐-☐☐☐☐

| Tax classification<br>☐ Corporation ☐ Partnership ☐ Individual/Sole Proprietor<br>☐ Other | ☐ Exempt from backup withholding |
|---|---|

**Remittance address** (address where payments should be sent)

| Street address | PO Box (if applicable) | City | State | Zip code |
|---|---|---|---|---|
| Telephone number | | Fax number | | |

**Physical location address** (physical address where services are rendered, if different from remittance address)

| Street address | City | State | Zip Code |
|---|---|---|---|
| Telephone number | Fax number | | |

**Correspondence address** (address where correspondence should be sent)

| Street address | PO Box (if applicable) | City | State | Zip Code |
|---|---|---|---|---|
| Telephone number | | Fax number | | |

**Contact information**

| Contact name (person completing form) | Title |
|---|---|
| Telephone number | Fax number |

**Affidavit**

By completing, signing, and filing this form the business payee applicant (1) certifies that the information given above is current and true to the best of their knowledge and is no way misleading; (2) ensures that the correct information forwarded to WSI should any data change in the future.

**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 (3) I am a U.S. person (including a U.S. resident alien)
The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding

| **Signature of authorizing agent** | **Date** |
|---|---|

**SECTION 2 -** *Payee type (Please select the primary payee type)*

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

**SECTION 3 -** *Sign up for medical provider electronic communications*

If you would like to receive WSI provider news communications by e-mail, sign up below.

| Contact Name | E-Mail Address |
|---|---|
| | |

**SECTION 4 -** *Submission of form*

Return completed form (both pages) to:

Workforce Safety & Insurance
PO Box 5585
Bismarck ND 58506-5585

Fax 701-328-3820

Email ndwsi@nd.gov

For questions, contact WSI Customer Service 1-800-777-5033 or 701-328-3800

**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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