



Eastern Washington Center of Occupational Health & Education Letter of Intent

The Center of Occupational Health & Education (COHE) Program is a partnership between the Department of Labor & Industries (L&I or department), medical, and community resources, aimed at improving injured worker health outcomes. The COHEs are dedicated to expanding community expertise in both occupational health care and disability prevention.

The Eastern Washington Center of Occupational Health & Education (COHE) is focused on improving care outcomes for injured workers in 19 Eastern Washington Counties. The Center is sponsored by Inland Northwest Health Services and St. Luke's Rehabilitation Institute. Health Care Coordination is an important COHE service that helps providers work with patients and their employers, as well as providing claim- specific services for coordinating care and tracking recovery challenges. The COHE Health Services Coordinators are located in the Spokane, Yakima, Tricities and Wenatchee offices.

Qualified MDs, DOs, DCs, ARNPs, PA-Cs, and DPMs practicing in the 19 designated counties are eligible to apply for participation. To be qualified, the provider must have an active L&I Provider Account Number in the respective facility(ies) and be approved in Labor and Industries new Medical Provider Network .

By submitting this statement of interest, the listed organization is only expressing interest in participating in the Eastern WA COHE. This is not a commitment to participate, nor is it a guarantee that the provider/organization will be assured status as a COHE participating provider. The final application steps include: 1) an orientation/training session for applicant providers and suitable clinic/facility support staff; 2) followed by signature and fax/delivery of the *L&I Provider Account Application Supplement for Attending Providers* to the E WA COHE Office.

Date: _____

List Providers (MD, DO, DC, ARNP, PA-C)

Practice/ Facility Name: _____

Name _____

L&I Provider #: _____

Practice/ Facility Address: _____

Name _____

L&I Provider #: _____

Practice/ Facility City, State and Zip Code: _____

Name _____

L&I Provider #: _____

Contact Person Name: _____

Name _____

L&I Provider #: _____

Contact Person Telephone Number: _____

Name _____

L&I Provider #: _____

Contact Person Email Address: _____

Name _____

L&I Provider #: _____

After submitting this statement (fax to the number below), the listed organization will be contacted by COHE staff to schedule the informational overview and mandatory provider and support staff orientation & training.

Eastern WA COHE

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