

**Provider Enrollment Form**

**U.S. Department of Labor  
Employment Standards Administration  
Office of Workers' Compensation Programs**



OMB Number 1215-0137  
Expires:

**Please refer to instructions for completing this form.**

Provider Number	Effective Date
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**FOR DOL USE ONLY**

1. Are you applying for a new enrollment or updating your record? If update, enter Provider Number or EIN:	<input type="checkbox"/> New enrollment	<input type="checkbox"/> Update
2. What is the earliest date that you treated a participant in any OWCP program?		

**Practice Information**

3. Practice Name	4. Address	
5. City	6. State	7. Zip (9 digits)
8. Telephone	9. FAX	
10. Type of Practice a. <input type="checkbox"/> Individual      b. <input type="checkbox"/> facility (For Individual or Facility, complete indicated sections below) c. <input type="checkbox"/> Group (Please see reverse for completion of group enrollment)		

**Provider Type (Individual or Facility)**

11a. Provider Type Number	11b. Provider Type
11c. If you select "Other Provider" (96) or Non-Medical Vendor (53), please explain:	
12. Tax ID: EIN	SSN
13. Medicare Number (required for hospitals only)	

**License and Certification (Individual for M.D. and D.O. only)**

14a. Name	14b. License #/ State	14c. Current Lic Expiration Date	14d. Specialty Code(s)	14e. Certification Expiration Date

15. United Mine Workers<sup>1</sup> of American (UMWA) Number, if applicable:

**Billing Address—indicate "same" if identical to Practice Address.**

16a. Address			
16b. City	16c. State	16d. Zip (9 digits)	

17.  I have completed a form for Electronic Funds Transfer (EFT).

18.  I am interested in billing electronically

**NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.**

Signature (Provider or Representative and Title)	Date
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**Group Provider Enrollment — #10c**

For group practice enrollment, please enter the following information for **each professional** who will provide services under the group EIN. Select from the attached list the Provider Type code that most closely describes the service(s) that the professional provides. Attach separate sheet for additional entries if necessary.

Name	SSN #	Prov Type Code	License #/ State	Current Lic# Exp Date	Specialty Code(s)	Certification Exp Date

Please return this completed form to the appropriate program at the following address to prevent a delay in the processing of your bills.

<i>For Federal Employees' Compensation Act (FECA) Program:</i>	<i>For Black Lung Program:</i>	<i>For Energy Program:</i>	<i>For Longshore Program:</i>
ACS P.O. Box 14600 Tallahassee, FL 32317-4600	DOL Black Lung Program P.O. Box 13200 Tallahassee, FL 32317-3200	DOL Energy Program P.O. Box 13400 Tallahassee, FL 32317-3400	Division of Longshore and Harbor Workers' Compensation 200 Constitution Avenue, Room C-4315 Washington, D.C. 20210
If you have any questions regarding the completion of the form, please call Toll Free: 1-866-335-8319	If you have any questions regarding the completion of the form, please call Toll Free: 1-800-638-7072	If you have any questions regarding the completion of the form, please call Toll Free: 1-866-335-8319	If you have any questions regarding the completion of the form, please call; 1-202-693-0925

**Privacy Act Statement**

(1) Collection of this information is authorized by the Federal Employees' Compensation Act (20 CFR 10.801), the Black Lung Benefits Act (20 CFR 725.704 and 725.705), the Energy Employees Occupational Illness Compensation Program Act of 2000 (20 CFR 30.701), and the Longshore and Harbor Workers' Compensation Act (20 CFR 702.503). (2) The information collected on this form will be used to ensure accurate medical provider information for payment of medical and vocational rehabilitation bills. (3) Disclosure of your Social Security Number and completion of this form is voluntary; however, failure to provide the information may result in bill payment delays. (4) This information may be furnished to data-processing contractors, to the Department of Labor and to the IRS in accordance with law. (5) Furnishing all requested information will facilitate accurate and timely payment for services to the provider.

**Public Burden Statement**

We estimate that it will take an average of 8 minutes to complete this information collection, including time for reviewing the instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this collection, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**DO NOT SEND THE COMPLETED FORM TO THE ABOVE ADDRESS**

## Provider Enrollment Form (Instructions)

A brief description of each data element is listed below. Be sure to sign and date the form when you submit it. For further information contact ACS or OWCP at the telephone numbers indicated on the form.

- Block 1** Indicate whether this form is being used for a new enrollment, or to update an existing enrollment record. If the form is being submitted to update your record, enter your Provider Number or EIN.
- Block 2** Indicate earliest date you treated any OWCP beneficiary.
- Block 3** Type or print your practice name.
- Block 4** Type or print your practice street address.
- Block 5** Type or print your practice city.
- Block 6** Type or print your practice state.
- Block 7** Type or print your practice zip code (all nine digits).
- Block 8** Type or print your practice telephone number.
- Block 9** Type or print your practice FAX number (if applicable).
- Block 10** Check your practice type—"a" for individual practice, "b" for a facility, or "c" for a group practice. Black Lung only: providers should disregard group practice information. If you checked "c" (group practice), fill out the appropriate parts of Block 10c on the reverse of the form for each professional that will be providing services under the group Provider Number (name, Social Security number, provider type code from list below, license number and State, expiration date of current license, specialty code or codes from the list below, and the date any certification expires). Continue on a separate sheet if necessary.
- Block 11a** If you checked "a" or "b" (individual practice or facility) in Block 10, type or print your "Provider Type" code from the list below.
- Block 11b** If you checked "a" or "b" (individual practice or facility) in Block 10, type or print the "Provider Type" that corresponds with the code you entered in Block 11a.
- Block 11c** If you checked "a" or "b" (individual practice or facility) in Block 10 and selected "Other Provider" (code 96) or "Non-Medical Vendor (code 53), please explain why you are enrolling.
- Block 12** If you checked "a" or "b" (individual practice or facility) in Block 10, type or print your Social Security number and/or your EIN, as appropriate.
- Block 13** If you checked "b" (facility) in Block 10, type or print your Medicare number (for hospitals only).
- Block 14a** If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O., type or print your name.

Block 14b If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O., type or print your license number and State. **Attach a copy of current M.D. or D.O. license.**

Block 14c If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O., type or print the expiration date of your current license. This license must be kept current to continue receiving payment.

Block 14d If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O., type or print your specialty code or codes from the list below.

Block 14e If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O., type or print the expiration date of any certification you currently hold.

Block 15 Type or print your UMWA Health & Retirement Funds Member Number, if any.

Block 16a Type or print the address where you want your Remittance Advices and paper checks to be sent. If this address is identical to your billing address above in Blocks 4 through 7, indicate "same" and skip Blocks 16b, 16c and 16d.

Block 16b Type or print your billing city if this is different from Block 5.

Block 16c Type or print your billing State if this is different from Block 6.

Block 16d Type or print your billing zip code (all nine digits) if this is different from Block 7.

Block 17 Indicate whether you have also completed a form for Electronic Funds Transfer (EFT).

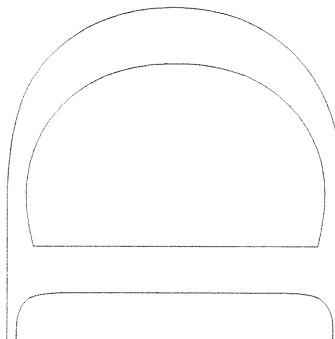
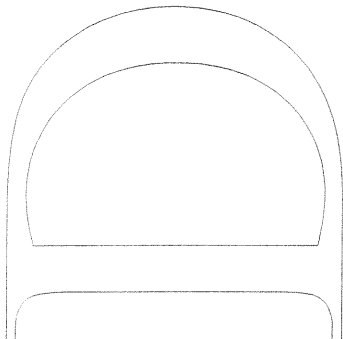
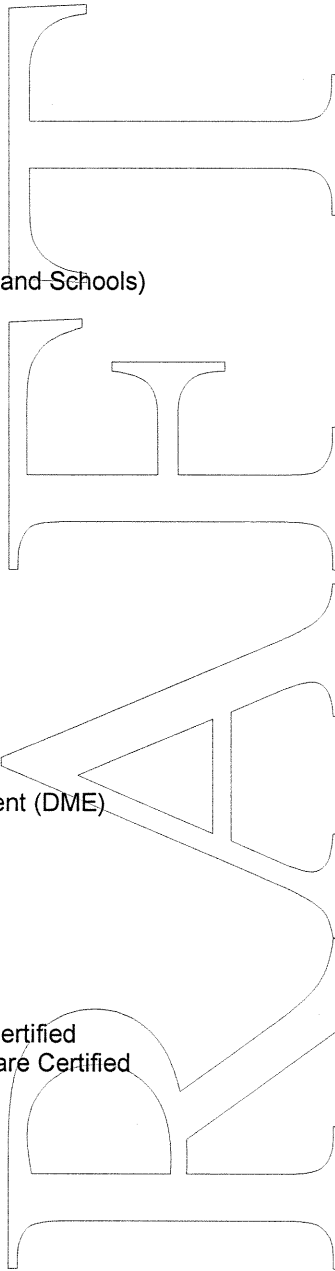
Block 18 Indicate whether you are interested in billing electronically.

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### Provider Type Codes (Blocks 10c, 11a and 11b)

- 01 General Hospital
- 02 Special Hospital/Outpatient Rehabilitation Facility
- 03 Psychiatric Hospital
- 05 Community Mental Health Center
- 19 End Stage Renal Hospital
- 20 Pharmacy
- 25 Physician (MD)
- 26 Physician (DO)
- 27 Podiatrist
- 28 Chiropractor
- 29 Physician Assistant
- 30 Advanced-Registered Nurse Practitioner (ARNP)
- 31 CRNA
- 32 Psychologist
- 34 Licensed Midwife
- 35 Dentist
- 36 Registered Nurse (RN)
- 37 Licensed Practical Nurse (LPN)
- 38 Nursing Attendant
- 39 Massage Therapist

- 40 Ambulance
- 41 Contract Nurse
- 42 Air/Water Ambulance Company
- 43 Taxi
- 44 Public Transportation
- 45 Private Transportation
- 46 Hospice
- 50 Independent Laboratory
- 51 Portable X-Ray Company
- 52 Alternative Medicine
- 53 Non-Medical Vendor
- 54 Prosthetics/Orthotics
- 55 Vocational Rehabilitation (Training, Tuition and Schools)
- 56 Vocational Rehabilitation Counselor
- 57 Rehabilitation Maintenance
- 58 Assisted Re-employment
- 59 Relocation Expenses
- 60 Audiologist/Speech Pathologist
- 61 Second Opinion Contractor
- 62 Optometrist
- 63 Optician
- 65 Home Health Agency
- 66 Rural Health Clinic
- 68 Federally Qualified Health Center
- 69 Birthing Center
- 70 HMO or PHP
- 71 Physical Therapist
- 72 Occupational Therapist
- 73 Pulmonary Rehabilitation
- 74 Outpatient Renal Dialysis Facility
- 75 Medical Supplies/Durable Medical Equipment (DME)
- 76 Case Management Agency
- 77 Social Worker
- 78 Blood Bank
- 79 Alternative Payee
- 80 Pay-to-Intermediary
- 88 Ambulatory Surgery Center
- 89 Federal Facility (VA Hospital)
- 90 Skilled Nursing Facility (SNF)—Medicare Certified
- 91 Skilled Nursing Facility (SNF)—Non-Medicare Certified
- 92 Intermediate Care Facility (ICF)
- 93 Rural Hospital Swing Bed
- 94 Boarding House
- 95 Insurance Company (Third Party Carriers)
- 96 Other Provider
- 97 Billing Agent
- 98 Lien holder



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### Provider Specialty Codes (Blocks 10c and 14d)

01	Adolescent Medicine	51	Rheumatology
02	Allergy	52	Abdominal surgery
03	Anesthesiology	53	Cardiovascular surgery
04	Cardiovascular Disease	54	Colon and rectal surgery
05	Dermatology	55	General surgery
06	Diabetes	56	Hand surgery
07	Emergency Medicine	57	Neurological surgery
08	Endocrine Medicine	58	Orthopedic surgery
09	Family Practice	60	Plastic surgery
10	Gastroenterology	61	Thoracic surgery
11	General Practice	62	Traumatic surgery
12	Preventative Medicine	63	Urological surgery
13	Geriatrics	64	Other physician specialty
14	Gynecology	65	Maternal fetal medicine
15	Hematology	70	Adult, dentures only
16	Immunology	71	General dentist
17	Infectious Diseases	72	Oral surgeon, dentist
18	Internal Medicine	74	Other dentist
20	Neoplastic Diseases	75	Adult primary care nurse practitioner
21	Nephrology	76	Clinical nurse specialist
22	Neurology	77	College nurse practitioner
24	Neuropathology	78	Diabetic nurse practitioner
25	Nutrition	80	Family/Emergency nurse
26	Obstetrics	82	Geriatric nurse practitioner
27	Obstetrics and Gynecology	84	Nurse anesthesiologist
28	Occupational Medicine	85	Nurse midwife
29	Oncology	86	OB/GYN nurse practitioner
30	Ophthalmology	88	Orthodontist
31	Otolaryngology	90	Occupational therapist
32	Pathology	91	Physical therapist
33	Pathology, clinical	92	Speech therapist
34	Pathology, forensic	93	Respiratory therapist
40	Pharmacology	95	Aged/disable waiver
41	Physical medicine and rehab	96	Develop services waiver
42	Psychiatry	97	Channeling waiver
44	Psychoanalysis	98	Comm supp living arrangement
45	Public Health	99	Other
46	Pulmonary diseases		
47	Radiology		
48	Diagnostic radiology		
50	Therapeutic radiology		

