How to Complete a Provider Enrollment Application

GROUP PROVIDER(S)

How to Complete a Provider Enrollment Application

- The Purpose of the Enrollment Application
- How to Complete an Application for a Group
- What Types of Credentials are Required
- How to submit your Provider Enrollment Application

All practice types (Individual/Facility/Group), **must** complete this section of the application.

Provider Enrollment Form Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs

OMB Number 1240-0021
Expires: 05/31/2019

Please refer to instructions for completing this form.

Provider Number | Effective Date

FOR DOL USE ONLY

1. Are you applying for a new enrollment or updating your record? ☐ New enrollment ☐ Re-enrollment ☐ Update

If update or re-enrollment, enter Provider Number or Employer Identification Number (EIN): _____

1a. Program
☐ FECA
☐ Black Lung
☐ Energy

2. What is the earliest date that you treated a participant in any OWCP program?

Block 1: Indicate whether this form is being used for a new enrollment, or to update an existing enrollment record. *

Note: If the form is being submitted to update your record, enter your Provider Number or Employer Identification Number.

Block 1a: Check the program in which you want to enroll as a provider. *

Note: If the provider wants to enroll in additional programs, a separate application is required for each program

* **If data is missing from these fields, the application will be Returned to the Provider (RTP)**

Completing an Enrollment Application

Provider Enrollment Form | Reset | Print

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If update or re-enrollment, enter Provider Number or Employer Identification Number (EIN): _____

1a. Program
☐ FECA
☐ Black Lung
☐ Energy

2. What is the earliest date that you treated a participant in any OWCP program? Ex. 2/22/2015

Block 2: Indicate earliest date you treated any OWCP participant.

- Practice Information **(Section 3)**
- **All** practice types (Individual/Facility/Group), **must** complete this section of the application.

3. Practice Name	Provider Company Inc.		4. Practice's Physical Address	4090 Corporate Street	
5. City	Corporate Town		6. State FL	7. Zip (9 digits)	51551-5555
8. Telephone	999-999-9999	9. FAX 999-999-9999	9a. Business Email Address	Corporate@Corp.Com	

Box 3: The provider should type/print their practice name
Box 4: The provider should type/print their practice physical address (**P.O. Box is not acceptable - RTP**)
Box 5: The provider should type/print their practice city
Box 6: The provider should type/print their practice state
Box 7: The provider should type/print their zip code (all 9-digits)
Box 8: The provider should type/print their practice phone number
(Note: if the provider submits a cell phone # for the practice, the provider must submit a copy of their cell phone bill. The address on the bill MUST match the address in box 4)
Box 9 & 9a: The provider should include fax number and business email address if available (not required)

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Provider Enrollment Form - U.S. Department of Labor

Providers **MUST** Select a Type of Practice

CONDUENT

10. Type of Practice ☐ a. Individual ☐ b. Facility (Provider Types: 01, 02, 03, 05, 46, 89, 90, 92, 93, 94)

☑ c. Group (Please see reverse for completion of group enrollment)

This Practice is set up as a Sole Proprietorship ☐ Yes ☐ No

This Practice is set up as a Limited Liability Company (LLC) ☐ Yes ☐ No

A. Individual Provider:

- A single provider (medical or non-medical)
- Not part of a group or facility
- Has an individual license and/or certification

B. Facility Provider:

- Provider is a hospital (ex. psychiatric facility)
- Has one of the following provider types (01, 02, 03, 05, 46, 89, 90, 92, 93, 94)
- Has a Medicare number
- Not an individual or group provider type

C. Group :

- Provider is an LLC., or Inc.
- Group practice has more than 1 provider affiliated with the group
- Provider is not a facility

NOTE: Black Lung only: providers should disregard group practice information

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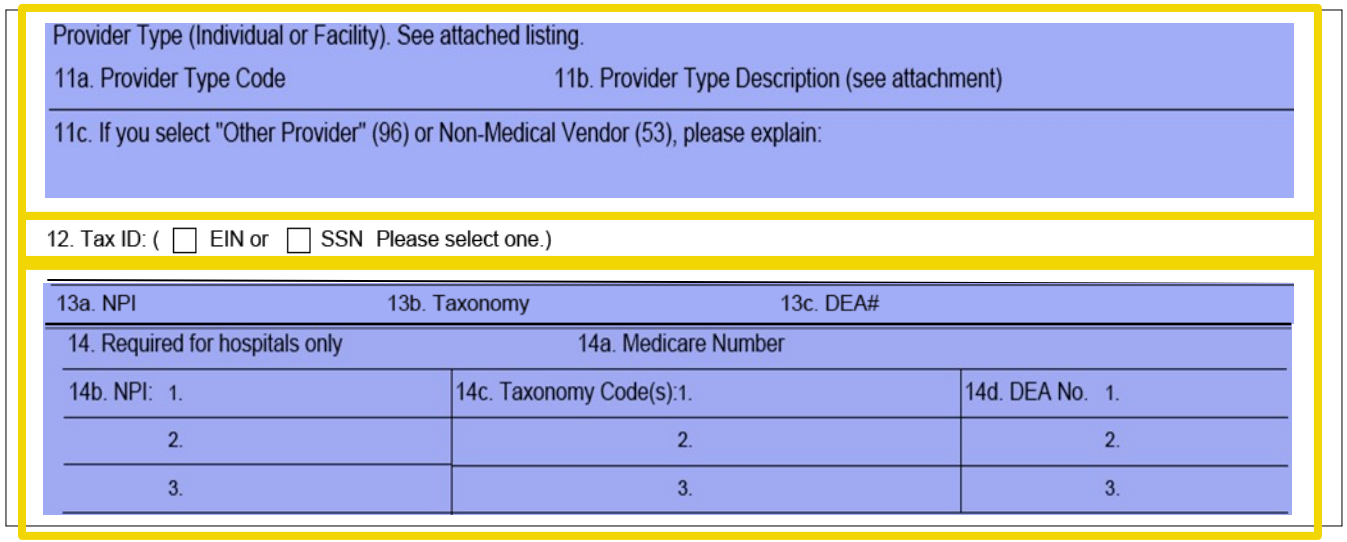

Provider Type (Individual or Facility). See attached listing.

11a. Provider Type Code | 11b. Provider Type Description (see attachment)

11c. If you select "Other Provider" (96) or Non-Medical Vendor (53), please explain:

12. Tax ID: (☐ EIN or ☐ SSN Please select one.)

13a. NPI	13b. Taxonomy	13c. DEA#

14. Required for hospitals only	14a. Medicare Number	
14b. NPI: 1.	14c. Taxonomy Code(s):1.	14d. DEA No. 1.
2.	2.	2.
3.	3.	3.

Block 11a through Block 11c: Is **NOT** required for a Group Provider

Block 12: The provider should check the box and type or print their SSN or EIN as appropriate**.** *
Note: If the provider is a sole proprietor they should use their SSN #
If the provider is an LLC, INC., etc., they should use their EIN #

Block 13a through Block 13c is **NOT** required for a Group Provider

Block 14a through Block 14d is **NOT** required for a Group Provider

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CONDUENT

If the provider checked "c" for group provider, they must complete boxes 17a through 20. *The provider MUST sign and date the enrollment application or it will be returned to provider and will NOT be processed

16. United Mine Workers' of America (UMWA) Number, if applicable.		
Billing Address-indicate "same" if identical to Practice Address.		
17a. Address		
17b. City	17c. State	17d. Zip (9 digits)
18. ☐ I have completed an ACH Vendor Payment/Electronic Funds Transfer (EFT) form.		
19. ☐ I am interested in billing electronically (check one): ☐ P2P Link ☐ EDI ☐ Web Submission		
20. ☐ I do not wish to be included in an online searchable list of OWCP providers. Reason:		
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) Coral Jakes, MD	Date 1/24/2016	

Box 16: This box is only for Black Lung providers who have a UMWA Health & retirement Fund member #
Box 17a: The provider should type/print address where they want the Remittance Advice to be sent
Box 17b: The provider should type/print billing city if this is different from block # 5
Box 17c: The provider should type/print billing state if this is different from block # 6
Box 17d: The provider should type/print billing zip code (all nine digits), if this is different from block # 7
Box 18: The provider should check this box to indicate they have completed an ACH Vendor Payment
Box 19: If the provider is interested in electronic billing they should check the box and indicate one of the 3 methods
Box 20: If the provider does not wish to be included in an online searchable list of OWCP providers, they must check this box and indicate the reason

Signature/date: The provider MUST sign and date the enrollment application *

Completing an Enrollment Application

Provider Enrollment Form - U.S. Department of Labor

- **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 the Provider Type code (from the list attached to the application) that most closely describes the service(s) that the provides.**

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 list on page 4 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/EIN (Please circle one)	Provider Type Code	License No./ State	Current License No. Expiration Date	Specialty Code(s)	NPI	Certification Expiration Date	Certificate Type

***If data is missing from these fields, the application will be Return to Providers (RTP)**

Disclosure Statement: Within ten years of the date of this statement have you or any individual listed on this application had an action related to fraud or abuse in a government program taken against him or her resulting in (1) a felony or misdemeanor conviction; (2) a liability finding in civil proceedings; or (3) a settlement entered into in lieu of conviction? ☐Yes ☐No

If Yes, provide details including type of action, Agency undertaking adverse action and date of action.

I, the undersigned, certify to the following: I have read the contents of this application, and the information contained herein is true, correct, and complete. I authorize the contractor, to verify the information contained herein. I agree to notify the contractor, of any change in ownership, practice location and/or Final Adverse Action involving fraud or abuse within 30 days of the reportable event. In addition, I agree to notify the contractor, of any other changes to the information in this form within 90 days of the effective date of change.

I also certify that I am not currently sanctioned, suspended, debarred, or excluded by any Federal or State Health Care Program, (e.g., Medicare, Medicaid, or any other Federal program), or otherwise prohibited from providing services to Medicare, Medicaid, or other Federal program beneficiaries nor are any owners, officers, or managing employees of the practice listed in this application.

Print Signature and Title _____

Signature and Title Date

- Provider must check either Yes or No
- Any provider that indicates “Yes” on the disclosure statement will not be initially enrolled. The provider application will be forwarded to DOL for review and final decision
- Provider must print name and title
- Provider must sign and date

* **If data is missing from these fields, the application will be Returned to the Provider (RTP)**

Once the enrollment application is completed, the provider will mail the application to the appropriate program shown below. **The completed enrollment form must be accompanied by a completed ACH Vendor Payment Information Form or it will be returned to the provider.**

For Federal E Compensatio (FECA) Prog		ıergy Program
OWCP/FECA P.O. Box 830 London, KY 40742-8300		IC ox 8304 n, KY -8304
If you have a questions reg completion o please call To 844-493-196		have any ons regarding the etion of the form, call Toll Free: 1- 72-2682

How to Complete a Group Provider Enrollment Application _Training Complete

Exit