

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

1a. Program

FECA

Black Lung

Energy

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

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



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1a. Program

FECA

Black Lung

Energy

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

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 <input type="text"/>	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)

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

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Provider Enrollment Form - U.S. Department of Labor
Providers **MUST** Select a Type of Practice



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





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: (<input type="checkbox"/> EIN or <input type="checkbox"/> 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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Provider Enrollment Form - U.S. Department of Labor



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)

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Provider Enrollment Form - U.S. Department of Labor
Disclosure Statement - New Addition to the Provider Enrollment Application



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 Employee Compensation (FECA) Program		Energy Program
OWCP/FECA P.O. Box 830 London, KY 40742-8300		IC Box 8304 London, KY 40742-8304
If you have any questions regarding completion of the form, please call Toll Free: 1-844-493-1961		If you have any questions regarding the completion of the form, please call Toll Free: 1-844-493-1961



How to Complete a Group Provider Enrollment Application _Training Complete

