

How to Complete a Provider Enrollment Application

FACILITY PROVIDER



How to Complete a Provider Enrollment Application



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



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

Provider Enrollment Form Reset Print	U.S. Department of Labor Office of Workers' Compensation Programs	
Please refer to instructions for completing this form.	OMB Number 1240-00 Expires: 05/31/20	
Provider Number	Effective Date	,10
1. Are you applying for a new enrollment or updating your record?	New enrollment Re-enrollment Update 1a. Program	n
	☐ FECA	
If update or re-enrollment, enter Provider Number or Employer Idea	ntification Number (EIN):	ung
	Energy	
2. What is the earliest date that you treated a participant in any OW	VCP program?	
Block 1: Indicate whether this form is being used for a rexisting enrollment record. Note: If the form is being submitted to update your readentification Number.		
Block 1a: Check the program in which you want to enro Note: If the provider wants to enroll in additional proprogram	-	

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

Completing an Enrollment Application CONDUENT 🚴



U.S. Department of Labor Office of Workers' Compensation Programs	
	ber 1240-0021
Effective Date USE ONLY	es: 05/31/2019
New enrollment Re-enrollment Update	1a. Program
	FECA
tification Number (EIN):	Black Lun
	Energy
CP program? Ex. 2/22/2015	
ou treated any OWCP partici	nant.
t	Office of Workers' Compensation Programs OMB Num Expire Effective Date USE ONLY New enrollment Re-enrollment Update itification Number (EIN):

Completing an Enrollment Application Provider Enrollment Form - U.S. Department of Labor





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

3. Practice Nar	me Provider Comp	any Inc.	4. Practice's Ph	ysical Address	4090 Corpora	ate Street
5. City	rporate Town			6. State FL	7. Zip (9 digits)	51551-5555
8. Telephone	999-999-9999	9. FAX 999-9	999-9999	9a. Business Ema	ail Address Corp	oorate@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)

Completing an Enrollment Application Provider Enrollment Form - U.S. Department of Labor

Providers **MUST** Select a Type of Practice





10. Type of Practice	a. Individual	b. Facility (Provider Type	es: 01, 02, 03, 05, 46, 89, 90, 92, 93, 94)	
	C. Group (Please	see reverse for	completion o	of group enrollment)	
This Practice is set up	as a Sole Proprietors	nip	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







 If the provider checked "b" for facility, they must complete boxes 11a through 12.

Provider Type	e (Individual or Facility). S	ee attached listing.	
11a. Provider	Type Code	11b. Prov	rider Type Description (see attachment)
11c. If you se	lect "Other Provider" (96)	or Non-Medical Vendor (53), please explain:
12. Tax ID: (EIN or SSN Ple	ease select one.)	
13a. NPI	13	b. Taxonomy	13c. DEA#
Block 11b Block 11c	: The provider should t : If the provider is an in (53) – Non Medical Ve The services that will The provider should c Note: If the provider	ype or print the descrip dividual, and selected a endor, the provider mus be performed. * heck the box and type is a sole proprietor th	ler type." (A list of provider types are attached to the application) tion of the provider type selected in box 11a. a provider type of either (96) – Other Provider, or st type or print an explanation and a description of or print their SSN or EIN as appropriate. * ney should use their SSN # they should use their EIN #

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

Completing an Enrollment Application Provider Enrollment Form - U.S. Department of Labor

CONDUENT

If the provider checked "b" for facility, they must complete boxes 14a through 15d.



14. Required for hospitals only 14a. Medicare Number				
14b. NPI: 1. 14c. Taxonomy Code(s):1. 14d. DEA No. 1.				14d. DEA No. 1.
2.	2. 2.			2.
3.	3.			3.
License and/or Certification required for all Applicants				
15a. Name	15b. License No./ State	15c. Current License Expiration Date	15d	. Certification Expiration Date:

Block 14a: The hospital should type/print their Medicare number

Block 14b: The hospital should type/print their NPI number (Note: the provider can use as many lines as needed)

Block 14c The hospital should type/print their Taxonomy code (Note: the provider can use as many lines as needed)

Block 14d: The hospital should type/print their DEA number (Note: the provider can use as many lines as needed)

Block 15a: The hospital should type/print their Name

Block 15b: The hospital should type/print their license number and issuing state (BOTH must be on the

application)

Block 15c: The hospital should type/print their current license expiration date

Block 15d: If the provider has a certificate, the provider should type/print the certification expiration date

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

Completing Enrollment Application

Provider Enrollment Form - U.S. Department of Labor

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



16. United Mine Workers' of America (UMWA) Number, if applicable	Э.
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 Fundament	ds Transfer (EFT) form.
19. I am interested in billing electronically (check one):	P2P Link EDI Web Submission
20. Ido not wish to be included in an online searchable list of 0	DWCP providers. Reason:
NOTICE: Anyone who misrepresents or falsifies essential information subject to fine and imprisonment under applicable Federal laws.	on to receive payment from Federal funds may upon conviction be
Signature (Provider or Representative and Title) Coral Ja	Nate 1/24/2016
Box 16: This box is only for Black Lung providers who have Box 17a: The provider should type/print address where the Box 17b: The provider should type/print billing city if this is Box 17c: The provider should type/print billing state if this is Box 17d: The provider should type/print billing zip code (all Box 18: The provider should check this box to indicate the Box 19: If the provider is interested in electronic billing the Box 20: If the provider does not wish to be included in an check	y want the Remittance Advice to be sent different from block # 5 s different from block # 6 nine digits), if this is different from block # 7 by have completed an ACH Vendor Payment

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

Completing an Enrollment Application

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



sclosure Statement: Within ten years of the date of this statement have you or any individual listed on this application had an ion related to fraud or abuse in a government program taken against him or her resulting in (1) a felony or misdemeanor enviction; (2) a liability finding in civil proceedings; or (3) a settlement entered into in lieu of conviction?
es, provide details including type of action, Agency undertaking adverse action and date of action.
the undersigned, certify to the following: I have read the contents of this application, and the information contained herein is e, correct, and complete. I authorize the contractor, to verify the information contained herein. I agree to notify the contractor, of y change in ownership, practice location and/or Final Adverse Action involving fraud or abuse within 30 days of the reportable ent. In addition, I agree to notify the contractor, of any other changes to the information in this form within 90 days of the ective date of change.
so certify that I am not currently sanctioned, suspended, debarred, or excluded by any Federal or State Health Care Program, g., Medicare, Medicaid, or any other Federal program), or otherwise prohibited from providing services to Medicare, Medicaid, other Federal program beneficiaries nor are any owners, officers, or managing employees of the practice listed in this olication.
nt Signature and Title
pnature 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.







How to Complete a Facility Provider Enrollment Application _Training Complete

