# Dear Provider:

Thank you for your interest in participating as a medical services provider for the four programs administered by the U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP). The OWCP administers four major disability compensation programs which provide benefits to certain workers or their dependents who experience work-related injury or occupational disease. These programs include the Division of Federal Employees’ Compensation (DFEC), the Division of Energy Employees Occupational Illness Compensation (DEEOIC), the Division of Coal Mine Workers’ Compensation (DCMWC), and the Division of Longshore and Harbor Workers’ Compensation (DLHWC).

OWCP has contracted to provide medical bill processing services for these four programs. As part of their benefit structure, these programs reimburse medical and non-medical providers for services rendered for the care and treatment of a claimant’s compensable condition.

OWCP can only process bills from providers who have enrolled. To enroll, complete the enclosed provider enrollment form to be assigned a provider identification number. Instructions for completing the enrollment form and a list of provider types are enclosed. Any Provider Enrollment Form that is received with missing or incomplete information will be returned to the submitter for correction and/or completion.

The Debt Collection Improvement Act of 1996 requires that payments made by the Federal Government be sent by electronic funds transfer (EFT). EFT payments are mandatory because it simplifies the process, reduces the incidents of billing error, and allows for expedited handling. An enrollment form for EFT is enclosed. A remittance advice listing all bills paid on each EFT transaction will be sent to your mailing address. Please see notice on page 2.

**You must submit current licensure information with your enrollment application. Moreover, each provider must maintain appropriate current licensure in order to receive payments under OWCP's programs.**

**Group practices are responsible for monitoring the licensure of each servicing provider in the practice. Where large group practices have providers in the group who are not providing medical services to our program on a regular basis, the group practice is responsible for monitoring the licensure of each provider who practices in the entire group.**

# Providers are required to enroll for each office location. Servicing providers under a group practice are not required to enroll separately.

You may register as a participant in any one or more of the following four OWCP compensation programs – DFEC, DEEOIC, DCMWC, and DLHWC. Please send the completed package(s)) at the address listed on the signature page (page 8) in the Form OWCP-1168.

To assist claimants seeking medical services, OWCP has an on-line listing of providers, by program that is searchable by: specialty, name, city, state, and zip code. Customers will be advised that a provider listing is not an endorsement, referral, or an agreement to reimburse for medical services rendered by the Department of Labor or OWCP. Nor does it guarantee that a medical provider will be reimbursed by OWCP for specific medical services or that a medical provider will agree to provide medical services to a particular claimant.

You will be notified by mail once your enrollment package has been processed. Once you have received your OWCP provider number, you may submit bills to the appropriate program at the following address(s):

U.S. Department of Labor OWCP/DFEC

P. O. Box 34450

San Antonio, TX 78265

U.S. Department of Labor OWCP/DEEOIC

P. O. Box 34930

San Antonio, TX 78265

U.S. Department of Labor OWCP/DCMWC

P. O. Box 34927

San Antonio, TX 78265

U.S. Department of Labor OWCP/DLHWC

P. O. Box 34927

San Antonio, TX 78265

If you have any questions regarding this information, please contact us at:

1-844-493-1966

Our business hours are Monday through Friday from 8:00 a.m. to 8:00 p.m., Eastern Time.

NOTICE: Please be aware that the information being requested on Department of Treasury SF 3881- Payment Information Form ACH Vendor Payment System - is required as part of the Department of Treasury Regulation 31 C.F.R. Part 208. This federal regulation, in part, requires that all agencies issuing federal payment do so via Electronic Fund Transfer (EFT). This includes but is not limited to the requirement of requesting a bank signature. Failure to include this information at the time the provider enrollment and ACH Payment Information forms are submitted will result in the return of these documents to the provider.

**NOTICE: Continued participation as a medical provider under the four DOL programs above can be contingent on your maintaining good standing as a medical provider under other federal health benefit programs such as Medicare. Exclusion as a medical provider in those circumstances operates as an automatic exclusion under the DFEC, DEEOIC and DLHWC Programs administered by OWCP. (See 20 C.F.R. §§ 10.815, 30.715, and 702.431). You may also be subject to the federal government’s suspension and debarment provisions. (See 48 C.F.R. Subpart**

**9.4 and 2 C.F.R. Part 180).**

## Provider Enrollment Form

Print

**U.S. Department of Labor**

Office of Workers’ Compensation Programs

OMB Number 1240-0021

Reset

Expires: 05/31/20xx

1. Are you applying for a new enrollment or updating your record?

 New Enrollment  Re-Enrollment  Re-Validation  Update

1a. If Update, Re-Enrollment or Re-Validation,

Enter Provider ID or Federal Employer Identification Number (FEIN)

## PART A: BASIC INFORMATION (Required)

1. Enrollment Type

 Individual

 Group Practice (Please see Page 9 for completion of group practice enrollment)  Facility/Agency/Organization/Institution

1. Provider Type Select

(For multi-specialty group provider, select primary provider type)

If you select “Other Provider” (96) or Non-Medical Vendor (53) 3a. Please explain

1. Program

DFEC DCMWC DEEOIC DLHWC

1. Individual Information (If you enroll using SSN) 5a. Last Name

Reset

5b. First Name

5c. Middle Name

5d. SSN

1. Organization Information 6a. Organization Name

(Legal Business Name)

6b. Organization Business Name (Doing Business As)

6c. FEIN

7. National Provider Identifier (NPI)

8. Entity Type

8a. If Other, please explain

Select

9. Email Address

1. I do not wish to be included in an online searchable list of OWCP providers.

10a. Reason

## PART B: LOCATION (Required)

1. Location Contact Information 11a. Business Name

11f. Email Address

|  |  |  |  |
| --- | --- | --- | --- |
| 11b. Contact Last Name | |  | 11c. Contact First Name |
|  |
|  | | |
|  | | | 11e. Fax Number |
| 11d. Phone Number |  | |

1. Physical Address

12a. Address Line 1 Address Line 2

Address Line 3

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | |  | | 12d. Zip Code |
| 12b. City/Town | |  | 12c.State/Province | Select |
|  | | |  | |
|  | | | 12f. Country | | |
| 12e. County |  | |
|  | |

1. Mailing Address Same as Physical Address

13a. Address Line 1 Address Line 2

Address Line 3

13b. City/Town

13c. State/Province

13d. Zip Code

13e. County

13f. Country

Select

## PART C: TAXONOMY

1. Taxonomy a. b.

Code(s)

c. d. e.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PART D: OWNERSHIP DETAILS** | | | | |
|  | | | | |
| 15. Organization Owner |  |  |  | Reset |
|  |  |  |  |  |
| 15a. Organization Name |  |  |  | 15b. FEIN |
|  |  |  |  |  |
| 16. Individual Owner |  |  |  |  |
| 16a. Last Name |  | 16b. First Name |  | 16c. SSN |

1. Address

17a. Address Line 1 Address Line 2

Address Line 3

|  |  |  |
| --- | --- | --- |
| 17b. City/Town | 17c. State/Province Select | 17d. Zip Code |
| 17e. County | 17f. Country | |

Additional Ownership Information

18a. Organization Name

18b. FEIN

Reset

1. Organization Owner

19. Individual Owner

19a. Last Name

19b. First Name

19c. SSN

20. Address

20a. Address Line 1 Address Line 2

Address Line 3

|  |  |  |
| --- | --- | --- |
| 20b. City/Town | 20c. State/Province Select | 20d. Zip Code |
| 20e. County | 20f. Country | |

## PART E: LICENSE AND CERTIFICATION

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 21a. License/Certification Category Select | | | | 21b. Name |
|  | | | | 21d. License/Certification Number |
| 21c. License/Certification Type | |  | |
|  | | | |
|  | | | 21f. Expiration Date | |
| 21e. Initial Issue Date |  | |
|  | | |
| 21g. Issued State Select | | | 21h. Issuer Agency | |

21i. Web Link

21j. License/Certification not required by State.

21k. Please explain

Additional License*/*Certification

|  |  |  |
| --- | --- | --- |
| 22a. License/Certification Category | Select | 22b. Name |
|  |  |  |
|  |  |  |
| 22c. License/Certification Type |  | 22d. License/Certification Number |
|  |  |  |
|  |  |  |
| 22e. Initial Issue Date |  | 22f. Expiration Date |
|  |  |  |
|  |  |  |
| 22g. Issued State Select |  | 22h. Issuer Agency |

22i. Web Link

## PART F: IDENTIFIERS

1. Provider Identifier Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 23a. Identifier Type | | Select | | 23b. Identifier Value |
|  | | | |
|  | | | 23d. End Date | |
| 23c. Start Date |  | |
|  | |

1. Additional Provider identifier information

|  |  |  |  |
| --- | --- | --- | --- |
| 24a. Identifier Type | Select | | 24b. Identifier Value |
|  | |
| 24c. Start Date | | 24d. End Date | |

## PART G: EDI SUBMISSION METHOD

1. Mode of Submission. Check all applicable

Billing Agent/Clearinghouse Web Batch

Web Interactive None

FTP Secured Batch

## PART H: EDI SUBMITTER DETAILS

|  |  |  |
| --- | --- | --- |
| 26b. Start Date |  | 26c. End Date |
|  |
|  |

1. Billing Agent/Clearinghouse/Submitter Information 26a. Billing Agent/Clearinghouse OWCP ID

## PART I: EDI CONTACT DETAILS

1. EDI Contact Information

27a. Contact Title

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | 27c. First Name |
| 27b. Last Name |  | |
|  | | |
|  | | | 27e. Fax Number |
| 27d. Phone Number | |  |
|  |

27f. Email Address

1. Address

28a. Address Line 1 Address Line 2

Address Line 3

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | |  | | 28d. Zip Code |
| 28b. City/Town | |  | 28c. State/Province | Select |
|  | | |  | |
|  | | | 28f. Country | | |
| 28e. County |  | |
|  | | |

1. Additional EDI Contact Information 29a. Contact Title

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | 29c. First Name |
| 29b. Last Name |  | |
|  | | |
|  | | | 29e. Fax Number |
| 29d. Phone Number | |  |
|  |

29f. Email Address

1. Address

30a. Address Line 1 Address Line 2

Address Line 3

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | 30c. State/Province |  | 30d. Zip Code |
| 30b. City/Town | |  | Select |
|  | | |  | |
|  | | | 30f. Country | | |
| 30e. County |  | |
|  | |

## Privacy Act Statement

Collection of this information by OWCP is necessary for its administration of the Federal Employees’ Compensation Act, the Black Lung Benefits Act, the Longshore and Harbor Workers’ Compensation Act and the Energy Employees Occupational Illness Compensation Program Act, and is authorized under 20 CFR 10.800, 20 CFR 30.700, 20 CFR 702.145, 20 CFR 725.714 and 33 USC 918(b). The information provided will be used to ensure accurate payment of medical and vocational rehabilitation provider bills and is protected by the Privacy Act of 1974, as amended (5 USC 552a) in accordance with the following systems of records: DOL/GOVT-1, DOL/OWCP-4 DOL/OWCP-9 and DOL/OWCP-11, published in the Federal Register, Vol. 81, page 25766, April 29, 2016, or as updated and republished. Completion and submission of this form is voluntary; however, failure to provide the information (including SSN or FEIN) will result in substantially delayed payment of bills. This information will be furnished to OWCP and its data processing contractors and may also be disclosed to other federal and state agencies in connection with the administration of other programs, to the Department of Justice for litigation purposes, and to medical and other provider review boards. Additional disclosures may be made through the routine uses for information contained in the referenced systems of records.

## Public Burden Statement

Under the Paperwork Reduction Act., persons are not required to respond to a collection of information unless such collection displays a valid OMB control number. We estimate that it will take an average of 30 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.

## Notice

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or the claims examiner to ask about this assistance.

## 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 in lieu of conviction? Yes No

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

## Required for DFEC providers

For Provider Type “Medical Supplies/Durable Medical Equipment (DME) / Prosthetics / Orthotics” (75) only: Are you an accredited DMEPOS supplier enrolled with Medicare? Yes  No

If Yes, provide the phone number that you used in your Medicare DMEPOS enrollment.

## Confirm and Sign

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 OWCP to verify the information contained herein. I agree to notify the OWCP 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 OWCP 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.

I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to the Department of Labor, Office of Workers’ Compensation Program (OWCP), or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of OWCP billing privileges, civil damages, and/or imprisonment.

I agree to abide by the OWCP regulations and program instructions that apply to me or to the organization listed in Section 3A of this enrollment form. I understand that payment of a claim by OWCP is conditioned upon the claim and the underlying transaction complying with state and federal laws (including, but not limited to, the Federal anti-kickback statute) and OWCP regulations, and program instructions.

I have completed an ACH Vendor Payment/Electronic Fund Transfer (EFT) form.

Print Name and Title

Signature Date

## Print, sign and mail or fax form to the following address:

Provider Enrollment Department of Labor - OWCP

P. O. Box 34690

San Antonio, TX 78265

## Addendum 1: Individual Providers Information for Group Practice Enrollment (Part A)

Fill in this addendum to add, update or remove servicing providers for Group Practice as applicable.

* Reviewer will validate NPI for all servicing providers.
* Reviewer will also validate license and certificate for 9 or less servicing providers. For more than 9 providers, group is responsible for validating license and certificate.

1. 2. Individual Information (Applicable if enrolling using SSN)

Reset

Add Update Remove



2a. Last Name

2b. First Name

2c. Middle Name

2d. SSN

3. Organization Information (Applicable if enrolling using FEIN)

3a. Organization Name

3b. Organization Business Name

3c. FEIN

4. Provider Type

5. NPI

Select

1. Taxonomy a. b. c. d. e.
2. License/Certification Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **License/ Certification Category** | **License/Certification Type** | **License/ Certification Number** | **Issued State** | **Initial Issue Date** | **Expiration Date** |
| Select |  |  | Select |  |  |
| Select |  |  | Select |  |  |

Additional Addendum Information

1.

2. Individual Information (Applicable if enrolling using SSN)

Add Update

Remove

2a. Last Name

2c. Middle Name

2b. First Name

2d. SSN

Reset

**en**

**se/**

3. Organization Information (Applicable if enrolling using FEIN)

3a. Organization Name

3b. Organization Business Name

3c. FEIN

4. Provider Type

5. NPI

Select

6. Taxonomy a.

b.

c.

d.

e.

7. License/Certification Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **License/ Certification Category** | **License/Certification Type** | **License/ Certification Number** | **Issued State** | **Initial Issue Date** | **Expiration Date** |
| Select |  |  | Select |  |  |
| Select |  |  | Select |  |  |

## Addendum 2: Taxonomy Information (Part C)

Type or print additional Taxonomy information as applicable. Use additional sheet(s) as required.

|  |
| --- |
| **Taxonomy** |
|  |
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## Addendum 3: License and Certification (Part E)

Type or print additional license and certification information as applicable. Use additional sheet(s) as required

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. License/Certification Category Select | | | | | | 2. Name |
|  | | | | | | 4. License/Certification Number |
| 3. License/Certification Type | | |  | | |
|  | | | | | |
|  | | | | | 6. Expiration Date | |
| 5. Initial Issue Date | |  | | |
|  | | | | |
|  | | | | 8. Issuer Agency | | |
| 7. Issued State | Select | | |
|  | | | |

9. Web Link

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | 2. Name | |
| 1. License/Certification Category | | | Select | | |
|  | | | | | |
|  | | | | | | | 4. License/Certification Number |
| 3. License/Certification Type | |  | | | | |
|  | | | | | | |
| 5. Initial Issue Date | | | | | 6. Expiration Date | | |
|  | | | | 8. Issuer Agency | | | |
| 7. Issued State | Select | | |
|  | | | |

9. Web Link

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | | 2. Name | |
| 1. License/Certification Category | | Select | | |
|  | | | | |
|  | | | | | | 4. License/Certification Number |
| 3. License/Certification Type |  | | | | |
|  | | | | | |
| 5. Initial Issue Date | | | | 6. Expiration Date | | |
| 7. Issued State Select | | | 8. Issuer Agency | | | |

9. Web Link

## Addendum 4: Billing Agent/Clearinghouse Provider ID (Part H)

Type or print additional Billing Agent/Clearinghouse Provider IDs as applicable. Use additional sheet(s) as required.

|  |  |  |
| --- | --- | --- |
| **Billing Agent/Clearinghouse ID** | **Start Date** | **End Date** |
|  |  |  |
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## Instructions

A brief description of each data element is listed below. Be sure to sign and date the form when you submit it.

|  |  |  |
| --- | --- | --- |
| **Part A: Basic Information** | | |
|  |  |  |
| 1. | Indicate whether this form is being used for a New Enrollment, to Update an existing ACTIVE enrollment record, for a Re-Enrollment (previously enrolled provider was excluded, now has become re-eligible) or to Re-Validate currently enrolled but EXPIRED enrollment record. | Required |
| 1a. | If the form is being submitted to Update, Re-Enrollment or Re-Validate your record, enter your Provider Number or Federal Employer Identification Number.   * For Re-Validation and Re-Enrollment, complete all applicable sections, sign and send the form. * For Update, complete ONLY changed sections, sign and send the form. | Required if Update, Re- Enrollment or Re-Validate option is selected in 1 |
| 2. | Select Enrollment Type:  Individual   * Any provider who is eligible to receive a Type I National Provider Identifier (NPI) through the National Plan and Provider Enumeration System (NPPES). Providers eligible to receive an NPI are those who deliver medical or health services, as defined under Section 1861(s) of the Social Security Act, 42 U.S.C. 1395x(s). * Individuals providing only non-medical services, attendant care, or personal care services, who do not need an NPI.   Group Practice   * One or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment) and have formed a partnership or corporation or are employees of a person, partnership or corporation, or other entity owning or operating the health care facilities at which they practice. These entities have a Type II National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES). * Fill out the appropriate parts in Addendum 1 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 | Required  Refer to Appendix 2 for more information |
| below, NPI, DEA Number, Taxonomy, License or Certificate Type, License Number, Issue Date, Issue State and Expiration Date of current license). Continue additional sheet(s) as needed.  Facility/Agency/Organization/Institution   * An Inpatient or Outpatient Hospital, a Skilled Nursing Facility, an Intermediate Care Facility, a Clinic (RHC, FQHC, Hospital Based Clinic, Urgent Care), a Psychiatric Facility, a Mental Institution, a Durable Medical Equipment Supplier, a Free Standing Ambulatory Surgical Center, a Long Term Care Facility, an Independent Clinical Laboratory, a Free Standing Radiology, a Dialysis Center, a Pharmacy, a Partnership, a Corporation, or any other entity that furnishes or arranges for the furnishing of services for which payment is billed under the OWCP programs. It does not include individual practitioners or groups of practitioners. In addition, you must also be eligible to receive and currently possess, a Type II National Provider Identifier, available through the National Plan and Provider Enumeration System (NPPES). * Any entity other than individual who does not deliver medical care or health services and is thus ineligible for a National Provider Identifier |

|  |  |  |
| --- | --- | --- |
|  | (NPI) available through the National Plan and Provider Enumeration System (NPPES). This provider type can include Fiscal Intermediaries, Non-Emergency Transportation, etc. |  |
| 3. | Type or print Provider Type  For Group Practice, type or print primary Provider Type. | Required  Refer to Appendix 1 for more information |
| 3a. | Type or print explanation for Provider Type | Required if 53 or 96 is selected in 3. |
| 4. | Check the Program(s) in which you want to enroll as a provider. If mailing, please mail the application to P.O. Box as indicated on Page 8 of the application or fax a separate document. | Required  Refer to Appendix 3 for more information |
| 5. | Type or print Individual information | Required if enrolled using SSN |
| 5a. | Type or print provider’s Last Name | Required |
| 5b. | Type or print provider’s First Name | Required |
| 5c. | Type or print provider’s Middle Name |  |
| 5d. | Type or print SSN | Required |
| 6. | Type or print Organization information | Required if enrolled using FEIN |
| 6a. | Type or print Organization Name (i.e.) Legal Business Name | Required |
| 6b. | Type or print Organization Business Name (i.e.) Doing Business As | Required |
| 6c. | Type or print FEIN | Required |
| 7. | Type or print NPI | Refer to Appendix 3 for requirements |
| 8. | Type or print IRS W9 Entity Type. Select from following values:   * C Corporation * S Corporation * Individual/Sole Proprietor or single-member LLC * LLC Filing as C Corporation * LLC Filing as S Corporation * LLC Filing as Partnership * LLC Filing as Sole Proprietor * Others * Partnership | Required |
| 8a. | Type or print Reason | Required if selected *Others* in 8 |
| 9. | Type or print Email Address |  |

|  |  |  |
| --- | --- | --- |
| 10. | Select this option if you do not wish to be included in the OWCP online searchable program. However, selecting this option will not exclude your information in a FOIA (Freedom Of Information Act) request. |  |
| 10a. | Type or print Explanation | Required if checkbox is selected in 10 |

|  |  |  |
| --- | --- | --- |
| **Part B: Location Information** | | |
|  | Providers offering services at different location(s) are required to enroll separately for each location. Servicing providers under a group practice are not required to enroll separately. |  |
| 11. | Location Contact information | Required |
| 11a. | Type or print location Business Name | Required |
| 11b. | Type or print contact Last Name | Required |
| 11c. | Type or print contact First Name | Required |
| 11d. | Type or print Phone number | Required |
| 11e. | Type or print Fax number |  |
| 11f. | Type or print Email Address |  |
| 12. | Type or print Physical Address |  |
| 12a. | Type or print street Address Line 1 | Required |
|  | Type or print street Address Line 2 |  |
|  | Type or print street Address Line 3 |  |
| 12b. | Type or print City or Town | Required |
| 12c. | Type or print State or Province | Required for domestic address |
| 12d. | Type or print Zip (or postal) Code | Required |
| 12e. | Type or print County |  |
| 12f. | Type or print Country | Required for foreign address |
| 13. | Select this option if the mailing address is same as the physical address. Otherwise print or type Mailing Address |  |
| 13a. | Type or print street Address Line 1 |  |
|  | Type or print street Address Line 2 |  |
|  | Type or print street Address Line 3 |  |
| 13b. | Type or print City or Town |  |
| 13c. | Type or print State or Province |  |

|  |  |  |
| --- | --- | --- |
| 13d. | Type or print Zip (or postal) Code |  |
| 13e. | Type or print County |  |
| 13f. | Type or print Country |  |

|  |  |  |
| --- | --- | --- |
| **Part C: Taxonomy** | |  |
|  |  |  |
|  | Type or print Taxonomy |  |
| 14. | Use Addendum 1 for taxonomy for servicing providers  Use Addendum 2 for additional taxonomy codes. Use additional sheet(s) | Refer to Appendix 3 for requirements |
|  | as required. |  |

|  |  |  |
| --- | --- | --- |
| **Part D: Ownership Details** | | Part D is **optional.**  For DFEC and DEEOIC providers, list any business with more than a 5% interest in or where involvement is at an officer, director or agent of the company. |
|  |  |  |
| 15. | Type or print Organization Ownership information | If enrolled using FEIN |
| 15a. | Type or print Organization Name |  |
| 15b. | Type or print FEIN |  |
| 16. | Type or print Individual Ownership information | If enrolled using SSN |
| 16a. | Type or print individual Last Name |  |
| 16b. | Type or print individual First Name |  |
| 16c. | Type or print SSN |  |
| 17. | Type or print Ownership address |  |
| 17a. | Type or print street Address Line 1 |  |
|  | Type or print street Address Line 2 |  |
|  | Type or print street Address Line 3 |  |
| 17b. | Type or print City or Town |  |

|  |  |  |
| --- | --- | --- |
| 17c. | Type or print State or Province | For domestic address |
| 17d. | Type or print Zip (or postal) Code |  |
| 17e. | Type or print County |  |
| 17f. | Type or print Country | For foreign address only |
|  | Section 18 to 20 are for additional ownership information, use additional sheets as required |  |
| 18. | Refer to instructions for Section 15 | If additional sheets needed |
| 19. | Refer to instructions for Section 16 | If additional sheets needed |
| 20. | Refer to instructions for Section 17 | If additional sheets needed |

|  |  |  |
| --- | --- | --- |
| **Part E: License and Certification** | |  |
|  |  |  |
|  | * Please provide all license/certification required by your State to perform the service under your Provider Type. * If a license or certification is not required by the State, attach letter/ evidence from the State authority. * OWCP will verify all your license/certification with your State's license issuer agency before your enrollment can be approved. * After your enrollment is approved, you are responsible to keep your license/certification information up to date. * Expired license/certification will cause the termination of the provider status. * If you have a renewed license/certification under a different number, please make sure to enter it using the exactly same License/Certification Type. |  |
| 21. | * Use Addendum 1 for license and certification information of servicing providers for group practice enrollment. * Refer to Addendum 3 to add additional license and certification information. Use additional sheet(s), as required. | Refer to Appendix 3 for requirements |
| 21a. | Type or print license or certification category from following options:   * License * certification | Required |
| 21b. | Type or print Name | Required |
| 21c. | Type or print License or Certification Type | Required |
| 21d. | Type or print License or Certification Number | Required |

|  |  |  |
| --- | --- | --- |
| 21e. | Type or print License or Certification Initial Issue Date | Required |
| 21f. | Type or print License or Certification Expiration Date | Required |
| 21g. | Type or print License or Certification Issued State | Required |
| 21h. | Type or print License or Certification Issuer Agency | Required |
| 21i. | Type or print License or certification Web Link | Required |
| 21j. | Select this option if License or Certification is not required by State |  |
| 21k. | Type or print Explanation | Required if 25j. is selected |
| 22. | Additional License and Certification information. Refer to instructions for section 21. Use additional sheet(s) as required. |  |

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| --- | --- | --- |
| **Part F: Identifiers** | |  |
|  |  |  |
| 23. | Identifier information | Medicare number is required for hospitals (Provider type: 01, 02,  03) |
| 23a. | Type or print Identifier Value from below list of values:   * DEA Number * NPI * Other Provider ID * Previous Provider ID * Provider Medicare Number * United Mine Workers of America (UMWA) Number | Required |
| 23b. | Type or print Identifier Value | Required |
| 23c. | Type or print Start Date | Required |
| 23d. | Type or print End Date |  |
| 24. | Additional Identifier information. Refer to instructions for section 23. Use additional sheet(s) as required. |  |

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| --- | --- | --- |
| **Part G: EDI Submission Method** | |  |
|  |  |  |
| 25. | Select mode of Submission. Select all applicable options:  Billing For providers who use a 3rd party to bill. Agent/Clearinghouse  Web Interactive For entering (keying) bills directly in the System. |  |

|  |  |  |
| --- | --- | --- |
|  | FTP Secured Batch: For submitting files via an SFTP site.  Web Batch For upload/download of files in the system.  None For submissions through paper form ONLY.   * "Web Batch" method is often used by providers who submit their own HIPAA batch transactions. It allows a maximum file size of 50 MB. * Your EDI submission method is "FTP Secured Batch" if you submit and retrieve batches at a secure web folder assigned to you by OWCP. This method was designed with clearinghouses and billing agents in mind. It allows a maximum file size of 100 MB. * Don't select “None” if other submission method is selected. You can always submit paper form in addition to EDI Submission. |  |
|  |  |  |

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| --- | --- | --- |
| **Part H: EDI Submitter Details** | |  |
|  |  |  |
| 26. | Billing Agent/Clearinghouse information   * Your Billing Agent/Clearinghouse must be enrolled with OWCP first. * Please obtain the Billing Agent/Clearinghouse’s OWCP ID to complete this section. * If they are not yet enrolled, you can still complete your enrollment by temporarily choosing not to use Billing Agent/Clearinghouse. * You can add them later after they are enrolled with OWCP.   Refer to Addendum 4 for additional information. Use additional sheet(s) as required. | Required if Billing Agent/Clearinghouse selected in Part G |
| 26a. | Type or print Billing Agent/Clearinghouse OWCP ID | Required |
| 26b. | Type or print Start Date | Required |
| 26c. | Type or print End Date |  |

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| --- | --- | --- |
| **Part I: EDI Contact Details** | |  |
|  |  |  |
| 27. | EDI Contact information | Required if FTP Secured Batch or Web Batch is selected in Part G |
| 27a. | Type or print Contact Title | Required |
| 27b. | Type or print contact last name | Required |
| 27c. | Type or print contact First Name | Required |
| 27d. | Type or print contact Phone number | Required |

|  |  |  |
| --- | --- | --- |
| 27e. | Type or print contact Fax number |  |
| 27f. | Type or print contact Email Address |  |
| 28. | Type or print Contact Address |  |
| 28a. | Type or print street Address Line 1 | Required |
|  | Type or print street Address Line 2 |  |
|  | Type or print street Address Line 3 |  |
| 28b. | Type or print City or Town | Required |
| 28c. | Type or print State or Province | Required for domestic address |
| 28d. | Type or print Zip (or postal) Code | Required |
| 28e. | Type or print County |  |
| 28f. | Type or print Country | Required for foreign address |
| 29. | Additional EDI Contact information. Refer to instructions for Section 27 |  |
| 30. | Additional EDI Contact address. Refer to instructions for Section 28 |  |

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| --- | --- | --- |
| **Addendum 1: Servicing Providers Information** | | Required for enrollment type Group Practice |
| 1. | Select one option to add, update or remove a servicing provider:   * For New Enrollment, only Add action can be selected. * Type or print all the information for New and Update Action. * Type or print SSN or FEIN for Remove Action. * Servicing providers can be enrolled using SSN (individual) or FEIN (organization). | Required |
| 2. | Type or print Individual information | Required if enrolled using SSN |
| 2a. | Type or print Last Name | Required |
| 2b. | Type or print First Name | Required |
| 2c. | Type or print Middle Name |  |
| 2d. | Type or print SSN | Required |
| 3. | Type or print Organization information | Required if enrolled using FEIN |
| 3a. | Type or print Organization Name | Required |
| 3b. | Type or print Organization Business Name | Required |
| 3c. | Type or print FEIN | Required |

|  |  |  |
| --- | --- | --- |
| 4. | Type or print Provider Type | Required  Refer to Appendix 1 for more information |
| 5. | Type or print NPI | Refer to Appendix 3 for requirements |
| 6. | Type or print Taxonomy | Refer to Appendix 3 for requirements |
| 7. | Type or print License/Certification information | Refer to Appendix 3 for requirements |
|  | Type or print License or Certification Category from following options:   * License * certification | Required |
|  | Type or print License or Certification Type | Required |
|  | Type or print License or Certification Number | Required |
|  | Type or print License or certification Issued State | Required |
|  | Type or print License or certification Initial Issue Date | Required |
|  | Type or print License or certification Expiration Date | Required |

Refer to Part C instructions

**Addendum 2: Taxonomy**

Refer to Part E instructions

**Addendum 3: License and Certification**

Refer to Part H instructions

**Addendum 4: Billing Agent/Clearinghouse**

|  |  |  |
| --- | --- | --- |
| **Supporting Documents** | | Required, please attach copy of the applicable supporting document(s) |
|  |  |  |
| 1. | ACH Form | Required |
| 2. | Copy of License/Certification | Required if you provided License/Certification information in Part E |
| 3. | Other Supporting Document |  |
| 4. | Provider Enrollment Form Signature Page | Required |
| 5. | State Approval Letter | If you selected *License not required by state* option in Part E |

## Appendix 1: Provider/Hospital Type Codes

|  |  |  |  |
| --- | --- | --- | --- |
| 01 | General Hospital | 63 | Optician |
| 02 | Special Hospital/ Rehabilitation Facility | 65 | Home Health Agency |
| 03 | Psychiatric Hospital | 66 | Rural Health Clinic |
| 05 | Community Mental Health Center | 67 | DMA Consult Contractor |
| 20 | Pharmacy | 68 | Federally Qualified Health Center |
| 25 | Physician (MD) & Physician (DO) | 69 | Birthing Center |
| 27 | Podiatrist | 70 | Health Maintenance Organization or |
| 28 | Chiropractor |  | Preferred Health Plan |
| 29 | Physician Assistant | 71 | Physical Therapist |
| 30 | Advanced Registered Nurse Practitioner | 72 | Occupational Therapist |
|  | (ARNP) | 73 | Pulmonary Rehabilitation |
| 31 | Certified Registered Nurse Anesthetist | 74 | Outpatient Renal Dialysis Facility |
|  | (CRNA) | 75 | Medical Supplies/Durable Medical |
| 32 | Psychologist |  | Equipment (DME) /Prosthetics/Orthotics |
| 33 | Contract Medical Consultant | 76 | Case Management Agency |
| 34 | Licensed Midwife | 77 | Social Worker |
| 35 | Dentist | 78 | Blood Bank |
| 36 | Registered Nurse (RN) | 80 | Pay-to-Intermediary |
| 37 | Licensed Practical Nurse (LPN) | 88 | Ambulatory Surgery Center |
| 38 | Nursing Attendant | 89 | Federal Facility (VA Hospital) |
| 40 | Ambulance | 90 | Skilled Nursing Facility (SNF)-Medicare |
| 41 | Contract Nurse |  | Certified & Non-Medicare Certified |
| 42 | Air/Water Ambulance Company | 92 | Intermediate Care Facility (ICF) |
| 43 | Taxi | 93 | Rural Hospital Swing Bed |
| 44 | Public Transportation & Private | 94 | Boarding House |
|  | Transportation | 95 | Insurance Company (Third party Carriers) |
| 46 | Hospice | 96 | Other Provider |
| 47 | FOH-DMA Providers | 97 | Billing Agent |
| 50 | Independent Laboratory | 98 | Lien Holder |
| 51 | Portable X-Ray Company |  |  |
| 52 | Alternative Medicine (e.g., Massage |  |  |
|  | Therapist/Acupuncturist) |  |  |
| 53 | Non-Medical Vendor |  |  |
| 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 |  |  |

**Appendix 2: Enrollment Type/Provider Type**

Applicable provider types for each enrollment type are listed:

|  |  |
| --- | --- |
| **Enrollment Type** | **Provider Type** |
| Individual | 25, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 40, 41, 42, 43, 44, 47, 50, 51,  52, 53, 55, 56, 57, 58, 59, 60, 61, 62, 63, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74,  75, 76, 77, 78, 80, 88, 95, 96, 98 |
| Group Practice | 25, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 43, 52, 60, 62, 63, 65, 66, 68, 69,  70, 71, 72, 73, 74, 75, 76, 77, 96 |
| Facility/Agency/Organization/Institution | 01, 02, 03, 05, 20, 40, 42, 43, 44, 46, 50, 51, 53, 55, 57, 58, 59, 65, 66, 68, 69,  70, 73, 74, 75, 76, 78, 80, 88, 89, 90, 92, 93, 94, 95, 96, 98 |

## Appendix 3: Provider Type Matrix

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Provider Type** | **NPI required?** | **Taxonomy required?** | **License/Certification required?** | **Applicable Program(s)** | **Self-Enrollment allowed? \*\*** |
| 01 |  |  |  | All |  |
| 02 |  |  |  | All |  |
| 03 |  |  |  | All |  |
| 05 |  |  |  | All |  |
| 20 |  |  |  | All |  |
| 25 |  |  |  | All |  |
| 27 |  |  |  | All |  |
| 28 |  |  |  | All |  |
| 29 |  |  |  | All |  |
| 30 |  |  |  | All |  |
| 31 |  |  |  | All |  |
| 32 |  |  |  | All |  |
| 33 |  |  |  | DEEOIC |  |
| 34 |  |  |  | DFEC |  |
| 35 |  |  |  | All |  |
| 36 |  |  |  | All |  |
| 37 |  |  |  | All |  |
| 38 |  |  |  | All |  |
| 40 |  |  |  | All |  |
| 41 |  |  |  | DFEC |  |
| 42 |  |  |  | All |  |
| 43 |  |  |  | All |  |
| 44 |  |  |  | All |  |
| 46 |  |  |  | All |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Provider Type** | **NPI required?** | **Taxonomy required?** | **License/Certification required?** | **Applicable Program(s)** | **Self-Enrollment allowed? \*\*** |
| 47 |  |  |  | DFEC |  |
| 50 |  |  |  | All |  |
| 51 |  |  |  | All |  |
| 52 |  |  |  | All |  |
| 53 |  |  |  | All |  for DEEOIC |
| 55 |  |  |  | DFEC |  |
| 56 |  |  |  | DFEC |  |
| 57 |  |  |  | DFEC |  |
| 58 |  |  |  | DFEC |  |
| 59 |  |  |  | DFEC |  |
| 60 |  |  |  | All |  |
| 61 |  |  |  | All |  |
| 62 |  |  |  | All |  |
| 63 |  |  |  | All |  |
| 65 |  |  |  | All |  |
| 66 |  |  |  | All |  |
| 67 |  |  |  | DFEC |  |
| 68 |  |  |  | All |  |
| 69 |  |  |  | All |  |
| 70 |  |  |  | All |  |
| 71 |  |  |  | All |  |
| 72 |  |  |  | All |  |
| 73 |  |  |  | All |  |
| 74 |  |  |  | All |  |
| 75 |  |  |  | All |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Provider Type** | **NPI required?** | **Taxonomy required?** | **License/Certification required?** | **Applicable Program(s)** | **Self-Enrollment allowed? \*\*** |
| 76 |  |  |  | All |  |
| 77 |  |  |  | All |  |
| 78 |  |  |  | All |  |
| 80 |  |  |  | All |  |
| 88 |  |  |  | All |  |
| 89 |  |  |  | All |  |
| 90 |  |  |  | All |  |
| 92 |  |  |  | All |  |
| 93 |  |  |  | All |  |
| 94 |  |  |  | All |  |
| 95 |  |  |  | All |  |
| 96 |  |  |  | All |  |
| 97 |  |  |  | All |  |
| 98 |  |  |  | All |  |

\*\* If Self-Enrollment is not allowed for a certain provider type, please contact 1-844-493-1966.