Provider Enrollment Form Print Reset

U.S. Department of Labor

Office of Workers' Compensation Programs

OMB Number 1240-0021
Expires: 12/31/2023

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)

2. Enrollment Type

☐ Individual

☐ Group Practice (Please see Page 9 for completion of group practice enrollment)

☐ Facility/Agency/Organization/Institution

3. 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

4. Program

☐ DFEC ☐ DCMWC ☐ DEEOIC ☐ DLHWC

5. Individual Information (If you enroll using SSN) Reset

5a. Last Name

5b. First Name

5c. Middle Name

5d. SSN

6. 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 Select

8a. If Other, please explain

9. Email Address

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

10a. Reason

PART B: LOCATION (Required)

11. Location Contact Information

11a. Business Name

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

11f. Email Address

12. Physical Address

12a. Address Line 1

Address Line 2

Address Line 3

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

13. Mailing Address ☐ Same as Physical Address

13a. Address Line 1

Address Line 2

Address Line 3

13b. City/Town	13c. State/Province Select	13d. Zip Code
13e. County	13f. Country	

PART C: TAXONOMY

14. Taxonomy Code(s) a. b. c. d. e.

PART D: OWNERSHIP DETAILS (Optional)

15. Organization Owner

Reset

15a. Organization Name | 15b. FEIN

16. Individual Owner

16a. Last Name | 16b. First Name | 16c. SSN

17. 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

18. Organization Owner

Reset

18a. Organization Name | 18b. FEIN

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 - (Required for Individual and Facility/Agency/Organization enrollment types.) Group practice providers may skip Section E through I and go to Addendum 1.

21a. License/Certification Category Select	21b. Name
21c. License/Certification Type	21d. License/Certification Number
21e. Initial Issue Date	21f. Expiration 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

23. Provider Identifier Information

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

24. Additional Provider identifier information

24a. Identifier Type	Previous Provider ID	24b. Identifier Value	
24c. Start Date		24d. End Date	

PART G: SUBMISSION METHOD

25. Mode of Submission. Check all applicable

- ☐ Billing Agent/Clearinghouse
- ☐ Web Interactive
- ☐ FTP Secured Batch
- ☐ Web Batch
- ☐ None

PART H: EDI SUBMITTER DETAILS

26. Billing Agent/Clearinghouse/Submitter Information

26a. Billing Agent/Clearinghouse OWCP ID			
26b. Start Date		26c. End Date	

PART I: EDI CONTACT DETAILS

27. EDI Contact Information

27a. Contact Title

27b. Last Name | 27c. First Name

27d. Phone Number | 27e. Fax Number

27f. Email Address

28. Address

28a. Address Line 1

Address Line 2

Address Line 3

28b. City/Town | 28c. State/Province Select | 28d. Zip Code

28e. County | 28f. Country

29. Additional EDI Contact Information

29a. Contact Title

29b. Last Name | 29c. First Name

29d. Phone Number | 29e. Fax Number

29f. Email Address

30. Address

30a. Address Line 1

Address Line 2

Address Line 3

30b. City/Town | 30c. State/Province Select | 30d. Zip Code

30e. County | 30f. Country

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 certify that I and my agents have currently in effect all necessary licenses, certifications, approvals, insurance, etc. required to properly provide the services and/or supplies for the OWCP in the state, county, locality, or jurisdiction where the services and/or supplies are provided. I will provide proof of such licenses, certifications, approvals, insurance, etc. upon the OWCP's request. I understand that any revocation, withdrawal, or non-renewal of necessary license, certification, approval, insurance, etc. required for me to properly provide services, shall be grounds for termination of enrollment/registration by the OWCP.

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 8312
London, KY 40742-8312
Fax: 888-444-5335

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. ☐ Add ☐ Update ☐ Remove

2. Individual Information (Applicable if enrolling using SSN) — Reset

2a. Last Name | 2c. Middle Name

2b. First Name | 2d. SSN

3. Organization Information (Applicable if enrolling using FEIN)

3a. Organization Name

3b. Organization Business Name | 3c. FEIN

4. Provider Type: Select | 5. NPI

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			Others		
Select			Select		

Additional Addendum Information

1. ☐ Add ☐ Update ☐ Remove

2. Individual Information (Applicable if enrolling using SSN) — Reset

2a. Last Name | 2c. Middle Name

2b. First Name | 2d. SSN

3. Organization Information (Applicable if enrolling using FEIN)

3a. Organization Name

3b. Organization Business Name | 3c. FEIN

4. Provider Type: Select | 5. NPI

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

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:
3. License/Certification Type:	4. License/Certification Number:
5. Initial Issue Date:	6. Expiration Date:
7. Issued State: Select	8. Issuer Agency:
9. Web Link:	

1. License/Certification Category: Select	2. Name:
3. License/Certification Type:	4. License/Certification Number:
5. Initial Issue Date:	6. Expiration Date:
7. Issued State: Others	8. Issuer Agency:
9. Web Link:	

1. License/Certification Category: Select	2. Name:
3. License/Certification Type:	4. License/Certification Number:
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

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 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	Required Refer to Appendix 2 for more information

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

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 enrolling using FEIN
15a.	Type or print Organization Name	
15b.	Type or print FEIN	
16.	Type or print Individual Ownership information	If enrolling 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.	

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.	

Part G: EDI Submission Method		
25.	Select mode of Submission. Select all applicable options: Billing Agent/Clearinghouse — For providers who use a 3rd party to bill. 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.	

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	

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	

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

Addendum 2: Taxonomy	Refer to Part C instructions

Addendum 3: License and Certification	Refer to Part E instructions

Addendum 4: Billing Agent/Clearinghouse	Refer to Part H instructions

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
02	Special Hospital/ Rehabilitation Facility
03	Psychiatric Hospital
05	Community Mental Health Center
20	Pharmacy
25	Physician (MD) & Physician (DO)
27	Podiatrist
28	Chiropractor
29	Physician Assistant
30	Advanced Registered Nurse Practitioner (ARNP)
31	Certified Registered Nurse Anesthetist (CRNA)
32	Psychologist
33	Contract Medical Consultant
34	Licensed Midwife
35	Dentist
36	Registered Nurse (RN)
37	Licensed Practical Nurse (LPN)
38	Nursing Attendant
40	Ambulance
41	Contract Nurse
42	Air/Water Ambulance Company
43	Taxi
44	Public Transportation & Private Transportation
46	Hospice
47	FOH-DMA Providers
50	Independent Laboratory
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
63	Optician
65	Home Health Agency
66	Rural Health Clinic
67	DMA Consult Contractor
68	Federally Qualified Health Center
69	Birthing Center
70	Health Maintenance Organization or Preferred Health Plan
71	Physical Therapist
72	Occupational Therapist
73	Pulmonary Rehabilitation
74	Outpatient Renal Dialysis Facility
75	Medical Supplies/Durable Medical Equipment (DME) /Prosthetics/Orthotics
76	Case Management Agency
77	Social Worker
78	Blood Bank
80	Pay-to-Intermediary
88	Ambulatory Surgery Center
89	Federal Facility (VA Hospital)
90	Skilled Nursing Facility (SNF)-Medicare Certified & 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

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.