

Provider Enrollment Form

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

(For Update, ONLY complete sections you wish to change, then Confirm and Sign on page 8)

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

Enter Provider ID or Federal Employer Identification Number (FEIN)

PART A: BASIC INFORMATION (All fields in this section are required; if "other" is selected, explanation is required.)

2. Enrollment Type (Refer to Instructions for additional information)

Individual

Group Practice (Please see Page 9 - Addendum 1, for completion of group practice enrollment for each professional) Facility/Agency/Organization/Institution

3. Provider Type

(For multi-specialty group provider, select primary provider type. Refer to Appendix 1 & 3 for more information)

If selecting "Other Provider" (96) or Non-Medical Vendor (53), please complete 3a.:

3a. Please explain

4. Program (Check the Program(s) in which you want to enroll as a provider.)

DFEC

DCMWC

DEEOIC

DLHWC

5. Individual Information (If enrolling using SSN)

5a. Last Name

5c. Middle Name

5b. First Name

5d. SSN

6. Organization Information (If enrolling using FEIN)

6a. Organization Name
(Legal Business Name)

6b. Organization Business Name
(Doing Business As)

6c. FEIN

7. National Provider Identifier (NPI)
(Refer to Appendix 3)

8. Entity Type

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 (All fields are required. If not applicable specify N/A)

11. Location Contact 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.)

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

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

13d. Zip Code

13e. County

13f. Country

PART C: TAXONOMY (Required if applicable.)

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

PART D: OWNERSHIP DETAILS (Optional. Refer to Instructions for additional information.)

15. Organization Owner (If enrolling using FEIN)

15a. Organization Name

15b. FEIN

16. Individual Owner

16a. Last Name

16b. First Name

16c. SSN

17. Address (If enrolling using SSN)

17a. Address Line 1

Address Line 2

Address Line 3

17b. City/Town

17c. State/Province

17d. Zip Code

17e. County

17f. Country

Additional Ownership Information (Section 18 to 20 are for additional ownership information. Use additional sheets as required)

18. Organization Owner

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

20d. Zip Code

20e. County

20f. Country

**PART E: LICENSE AND CERTIFICATION (Required for Individual and Facility/Agency/Organization enrollment types.
Please refer to Instructions on page 14 for additional information.)
Group practice providers may skip Sections E and F, and continue at Section G through Addendum 1.**

21a. License/Certification Category	21b. Name
21c. License/Certification Type	21d. License/Certification Number
21e. Initial Issue Date	21f. Expiration Date
21g. Issued State	21h. Issuer Agency
21i. Web Link	
21j. License/Certification not required by State. (Select if License/Certification is not required by State)	
21k. Please explain	

Additional License/Certification (Use additional sheet(s) as required)

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

PART F: IDENTIFIERS

23. Provider Identifier Information (Medicare number is required for hospitals (Provider type: 01, 02, 03))

23a. Identifier Type

23b. Identifier Value

23c. Start Date

23d. End Date

24. Additional Provider identifier information (Use additional sheet(s) as required)

24a. Identifier Type

24b. Identifier Value

24c. Start Date

24d. End Date

PART G: EDI SUBMISSION METHOD

25. Mode of Submission. Check all applicable (See Instructions on page 15 for details regarding modes of submission)

Billing Agent/Clearinghouse

Web Interactive

FTP Secured Batch

Web Batch

None

PART H: EDI SUBMITTER DETAILS (Required if Billing Agent/Clearinghouse selected in Part G)

26. Billing Agent/Clearinghouse/Submitter Information (See Instructions for further details.)

26a. Billing Agent/Clearinghouse OWCP ID

26b. Start Date

26c. End Date

PART I: EDI CONTACT DETAILS (Required if submitting EDI)

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

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

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 25 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. (Please attach ACH 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: Servicing Providers Information for Group Practice Enrollment
(All fields are required for providers enrolled as Group Practice. Refer to Instructions and Appendices 1 and 3 for additional information.)

Fill in this addendum to add, update or remove servicing providers for Group Practice. Use additional sheet(s) as required.

1. Add Update Remove	2. Individual Information (If enrolling using SSN)	
	2a. Last Name	2c. Middle Name
	2b. First Name	2d. SSN

3. Organization Information (If enrolling using FEIN)	
3a. Organization Name	3c. FEIN
3b. Organization Business Name	

4. Provider Type	5. NPI
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6. Taxonomy a.	b.	c.	d.	e.
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7. License/Certification Information

License/ Certification Category	License/Certification Type	License/ Certification Number	Issued State	Initial Issue Date	Expiration Date

Additional Addendum Information

1. Add Update Remove	2. Individual Information (Applicable if enrolling using SSN)	
	2a. Last Name	2c. Middle Name
	2b. First Name	2d. SSN

3. Organization Information (Applicable if enrolling using FEIN)	
3a. Organization Name	3c. FEIN
3b. Organization Business Name	

4. Provider Type	5. NPI
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6. Taxonomy a.	b.	c.	d.	e.
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7. License/Certification Information

License/ Certification Category	License/Certification Type	License/ Certification Number	Issued State	Initial Issue Date	Expiration Date

Addendum 2: Taxonomy Information

Type or print additional Taxonomy information as applicable.

Use additional sheet(s) as required.

Taxonomy

Addendum 3: License and Certification

Type or print additional license and certification information as applicable.

Use additional sheet(s) as required

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

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

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

Addendum 4: Billing Agent/Clearinghouse Provider ID

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 and additional information for parts of the form is listed below. Be sure to sign and date the form when you submit it.

Part A: Basic Information		
1.	<p>New Enrollment - New Providers select when not previously enrolled with OWCP</p> <p>Re-Enrollment - Previously enrolled Provider was excluded, now has become eligible to enroll with OWCP</p> <p>Re-Validate - Current Provider who is enrolled with OWCP but has expired information on the provider enrollment record.</p> <p>Update - Current Provider who is enrolled with OWCP and needs to update existing information on the provider enrollment record</p>	Required
2.	<p>Select Enrollment Type:</p> <p>Individual</p> <ul style="list-style-type: none"> • 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. <p>Group Practice</p> <ul style="list-style-type: none"> • 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). <p>Facility/Agency/Organization/Institution</p> <ul style="list-style-type: none"> • 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. 	<p>Required</p> <p>Refer to Appendix 2 for more information</p>
10.	<p>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.</p>	

Part C: Taxonomy		
14.	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 provider type taxonomy requirements

Part D: Ownership Details (OPTIONAL)	<p>Part D is optional.</p> <p>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</p>
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Part E: License and Certification		
<ul style="list-style-type: none"> • Please complete and attach copies of 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 exact same License/Certification Type. 		Required for Individual and Facility/Agency/ Organizational enrollment types.
21.	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • License • certification 	If submitting a copy of your licenses and/or certifications skip 21b through 21i
21k.	Type or print Explanation and attach letter/evidence from State authority	Required if 21j. is selected

Part G: EDI Submission Method		
25.	<p>Select mode of Submission. Select all applicable options:</p> <p>Billing Agent/Clearinghouse For providers who use a 3rd party to bill.</p> <p>Web Interactive For entering (keying) bills directly in the System.</p> <p>FTP Secured Batch: For submitting files via an SFTP site.</p> <p>Web Batch For upload/download of files in the system.</p> <p>None For submissions through paper form ONLY.</p> <ul style="list-style-type: none"> • "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.	<p>Billing Agent/Clearinghouse information</p> <ul style="list-style-type: none"> • 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. <p>Refer to Addendum 4 for additional information. Use additional sheet(s) as required.</p>	Required if Billing Agent/Clearinghouse selected in Part G

Addendum 1: Servicing Providers Information		Required for enrollment type Group Practice
1.	<p>Select one option to add, update or remove a servicing provider:</p> <ul style="list-style-type: none"> • 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

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	Birth Center
27	Podiatrist	70	Health Maintenance Organization or Preferred Health Plan
28	Chiropractor		
29	Physician Assistant	71	Physical Therapist
30	Advanced Registered Nurse Practitioner (ARNP)	72	Occupational Therapist
		73	Pulmonary Rehabilitation
31	Certified Registered Nurse Anesthetist (CRNA)	74	Outpatient Renal Dialysis Facility
		75	Medical Supplies/Durable Medical Equipment (DME) /Prosthetics/Orthotics
32	Psychologist		
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 Certified & Non-Medicare Certified
41	Contract Nurse		
42	Air/Water Ambulance Company	92	Intermediate Care Facility (ICF)
43	Taxi	93	Rural Hospital Swing Bed
44	Public Transportation & Private Transportation	94	Boarding House
		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	✓

Previous editions unusable

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.