Print Reset

ACH VENDOR PAYMENT ENROLLMENT FORM

This form is used for Automated Clearing House (ACH) payments with an addendum record that contains payment-related information. Recipients of these payments should bring this information to the attention of their financial institution when presenting this form for completion. See page 2 for instructions in completing this form.

PAPERWORK REDUCTION ACT STATEMENT

The information being collected on this form is required under the provision of 31 U.S.C. 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data by electronic means to vendor's financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the Automated Clearinghouse Payment System.

MEDICAL PROVIDER INFORMATION			
OWCP Provider ID			
Name			
Address			
Contact Person Name		Telephone Number	

AGENCY INFORMATION	
Name: U.S. Department of Labor-Office of Workers' Compensation Program	
Address: Provider Enrollment	
P. O. Box 8312, London, KY 40742-8312	
Contact Person Name:	Telephone Number:

FINANCIAL INSTITUTION INFORMATION				
Name				
Street Address				
City		State	Select	Zip Code
ACH Coordinator Name		Telephone Number		
Nine-Digit Routing Transit Number				
Depositor Account Title				
Depositor Account Number				
Type of Account	☐ Checking	☐ Savings		
Signature and Title of Representative		Telephone Number		

ACH Vendor Payment Enrollment Form Instructions (OWCP- 3881)

Section 1: Medical Provider Information
Print or type the 9-digit OWCP provider number, the practice name and address. Print or type the name and telephone number of the provider's point of contact. **NOTE: If this is a new enrollment, a provider number is not required.**

Section 2: Agency Information
Federal agency information is pre-populated.

Section 3: Financial Institution Information
Print or type the Financial Institution's name and address. Print or type the Financial Institution ACH Coordinator's name and telephone number. Print or type the nine-digit routing transit number. Print or type the Depositor's Account Title. Print or type the Depositor's Account Number. Indicate the Type of Account, Checking or Savings. Provide a representative's signature, title, and telephone number. The representative could be from the provider's practice or the Financial Institution. Typed or stamped signatures are not acceptable.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1240-0NEW. This collection of information is voluntary. We estimate that it will take an average of three minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures and prior use of this common form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S3522, 200 Constitution Avenue NW, Washington, DC 20210; and reference OMB control number 1240-0NEW, Washington, DC 20503. DO NOT SEND THE COMPLETED FORM TO EITHER OF THIS OFFICE.

NOTICE

If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the OWCP 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 of changes to accommodate your disability. Please contact our office or your OWCP claims staff to ask about this assistance.