Provider Enrollment Form

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB Number 1215-0137
Expires: 03/31/2007

Please refer to instructions for completing this form.

Provider Number	Effective Date
FOR DOL USE ONLY	

1. Are you applying for a new enrollment or updating your record? ☐ New enrollment ☐ Update
   If update, enter Provider Number or EIN:

2. What is the earliest date that you treated a participant in any OWCP program?

Practice Information

3. Practice Name	4. Address	
5. City	6. State	7. Zip (9 digits)
8. Telephone	9. FAX	

10. Type of Practice
    a. ☐ Individual b. ☐ Facility (For Individual or Facility, complete indicated sections below)
    c. ☐ Group (Please see reverse for completion of group enrollment)

Provider Type (Individual or Facility)

11a. Provider Type Code	11b. Provider Type
11c. If you select "Other Provider" (96) or Non-Medical Vendor (53), please explain:	
12. Tax ID: EIN	SSN
13. Medicare Number (required for hospitals only)	

License and Certification (Individual for M.D. and D.O. only)

14a. Name	14b. License #/ State	14c. Current Lic Expiration Date	14d. Specialty Code(s)	14e. Certification Expiration Date

15. UMWA Health & Retirement Funds Member Number, if applicable:

Billing Address—indicate "same" if identical to Practice Address.

16a. Address		
16b. City	16c. State	16d. Zip (9 digits)

17. ☐ I have completed a form for Electronic Funds Transfer (EFT).

18. ☐ I am interested in billing electronically

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.

Signature (Provider or Representative and Title)	Date

Group Provider Enrollment — #10c

For group practice enrollment, please enter the following information for **each professional** who will provide services under the group EIN. Select from the attached list the Provider Type code that most closely describes the service(s) that the professional provides. Attach separate sheet for additional entries if necessary.

Name	SSN #	Prov Type Code	License #/ State	Current Lic# Exp Date	Specialty Code(s)	Certification Exp Date

Please return this completed form to the appropriate program at the following address to prevent a delay in the processing of your bills.

For Federal Employees' Compensation Act (FECA) Program:	*For Black Lung Program:*	*For Energy Program:*	*For Longshore Program:*
ACS P.O. Box 14600 Tallahassee FL 32137-4600	DOL Black Lung Program P.O. Box 13200 Tallahassee FL 32317-3200	DOL Energy Program P.O. Box 13400 Tallahassee FL 32317-3400	Division of Longshore and Harbor Workers' Compensation 200 Constitution Avenue, Room C-4315 Washington, D.C. 20210
If you have any questions regarding the completion of the form, please call Toll Free: 1-866-335-8319	If you have any questions regarding the completion of the form, please call Toll Free: 1-800-638-7072	If you have any questions regarding the completion of the form, please call Toll Free: 1-866-272-2682	If you have any questions regarding the completion of the form, please call; 1-202-693-0925

Privacy Act Statement

(1) Collection of this information is authorized by the Federal Employees' Compensation Act (20 CFR 10.801), the Black Lung Benefits Act (20 CFR 725.704 and 725.705), the Energy Employees Occupational Illness Compensation Program Act of 2000 (20 CFR 30.701), and the Longshore and Harbor Workers' Compensation Act (20 CFR 702.503). (2) The information collected on this form will be used to ensure accurate medical provider information for payment of medical and vocational rehabilitation bills. (3) Disclosure of your Social Security Number and completion of this form is voluntary; however, failure to provide the information may result in bill payment delays. (4) This information may be furnished to data processing contractors, to the Department of Labor and to the IRS in accordance with law. (5) Furnishing all requested information will facilitate accurate and timely payment for services to the provider.

Public Burden Statement

We estimate that it will take an average of 8 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

DCMWC Provider Enrollment Form (Instructions)

A brief description of each data element is listed below. Be sure to sign and date the form when you submit it. For further information contact ACS at 1-866-335-8319 (toll free). Highlighted fields indicate new enrollment requirements.

Block 1 — Indicate whether this form is being used for a new enrollment, or to update an existing enrollment record. If the form is being submitted to update your record, enter your Provider Number or EIN.

Block 2 — Indicate earliest date you treated any OWCP beneficiary.

Block 3 — Type or print your practice name.

Block 4 — Type or print your practice street address.

Block 5 — Type or print your practice city.

Block 6 — Type or print your practice state.

Block 7 — Type or print your practice zip code (all nine digits).

Block 8 — Type or print your practice telephone number.

Block 9 — Type or print your practice FAX number (if applicable).

Block 10 — Check your practice type—“a” for individual practice or “b” for a facility. DCMWC providers should disregard group practice information.

Block 11a — Type or print your “Provider Type” code from the list below.

Block 11b — If you checked “a” or “b” (individual practice or facility) in Block 10, type or print the “Provider Type” that corresponds with the code you entered in Block 11a.

Block 11c — If you checked “a” or “b” (individual practice or facility) in Block 10 and selected “Other Provider” (code 96) or “Non-Medical Vendor (code 53), please explain why you are enrolling.

Block 12 — If you checked “a” or “b” (individual practice or facility) in Block 10, type or print your Social Security number and/or your EIN, as appropriate.

Block 13 — If you checked “b” (facility) in Block 10, type or print your Medicare number (for hospitals and specialty hospitals only).

Block 14a — If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your name.

Block 14b — If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your license number and State. **Attach a copy of current M.D. or D.O. license.**

Block 14c — If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print the expiration date of your current license. This license must be kept current with DCMWC to continue receiving payment.

Block 14d	If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your specialty code or codes from the list below.
Block 14e	If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print the expiration date of any certification you currently hold.
Block 15	Type or print your UMWA Health & Retirement Funds Member Number, if any.
Block 16a	Type or print the address where you want your Remittance Advices and paper checks to be sent. If this address is identical to your billing address above in Blocks 4 through 7, indicate “same” and skip Blocks 16b, 16c and 16d.
Block 16b	Type or print your billing city if this is different from Block 5.
Block 16c	Type or print your billing State if this is different from Block 6.
Block 16d	Type or print your billing zip code (all nine digits) if this is different from Block 7.
Block 17	Indicate whether you have also completed a form for Electronic Funds Transfer (EFT).
Block 18	Indicate whether you are interested in billing electronically.

Provider Type Codes (Blocks 10c, 11a and 11b)

Code	Provider Type
01	General Hospital
02	Special Hospital/Outpatient Rehabilitation Facility
03	Psychiatric Hospital
05	Community Mental Health Center
19	End Stage Renal Hospital
20	Pharmacy
25	Physician (MD)
26	Physician (DO)
27	Podiatrist
28	Chiropractor
32	Psychologist
34	Licensed Midwife
35	Dentist
36	Registered Nurse (RN)
37	Licensed Practical Nurse (LPN)
38	Nursing Attendant
39	Massage Therapist
40	Ambulance
41	Contract Nurse
42	Air/Water Ambulance Company
43	Taxi
44	Public Transportation
45	Private Transportation
46	Hospice
50	Independent Laboratory
51	Portable X-Ray Company
52	Alternative Medicine
53	Non-Medical Vendor
54	Prosthetics/Orthotics
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
68	Federally Qualified Health Center
69	Birthing Center
70	HMO or PHP
71	Physical Therapist
72	Occupational Therapist
73	Pulmonary Rehabilitation
74	Outpatient Renal Dialysis Facility
75	Medical Supplies/Durable Medical Equipment (DME)
76	Case Management Agency
77	Social Worker
78	Blood Bank
79	Alternative Payee
80	Pay-to-Intermediary
88	Ambulatory Surgery Center
89	Federal Facility (VA Hospital)
90	Skilled Nursing Facility (SNF)—Medicare Certified
91	Skilled Nursing Facility (SNF)—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

Provider Specialty Codes (Blocks 10c and 14d)

Code	Specialty
01	Adolescent Medicine
02	Allergy
03	Anesthesiology
04	Cardiovascular Disease
05	Dermatology
06	Diabetes
07	Emergency Medicine
08	Endocrine Medicine
09	Family Practice
10	Gastroenterology
11	General Practice
12	Preventative Medicine
13	Geriatrics
14	Gynecology
15	Hematology
16	Immunology
17	Infectious Diseases
18	Internal Medicine
20	Neoplastic Diseases
21	Nephrology
22	Neurology
24	Neuropathology
25	Nutrition
26	Obstetrics
27	Obstetrics and Gynecology
28	Occupational Medicine
29	Oncology
30	Ophthalmology
31	Otolaryngology
32	Pathology
33	Pathology, clinical
34	Pathology, forensic
40	Pharmacology
41	Physical medicine and rehab
42	Psychiatry
44	Psychoanalysis
45	Public Health
46	Pulmonary diseases
47	Radiology
48	Diagnostic radiology
50	Therapeutic radiology
51	Rheumatology
52	Abdominal surgery
53	Cardiovascular surgery
54	Colon and rectal surgery
55	General surgery
56	Hand surgery
57	Neurological surgery
58	Orthopedic surgery
60	Plastic surgery
61	Thoracic surgery
62	Traumatic surgery
63	Urological surgery
64	Other physician specialty
65	Maternal fetal medicine
70	Adult, dentures only
71	General dentist
72	Oral surgeon, dentist
74	Other dentist
75	Adult primary care nurse practitioner
76	Clinical nurse specialist
77	College nurse practitioner
78	Diabetic nurse practitioner
80	Family/Emergency nurse
82	Geriatric nurse practitioner
84	Nurse anesthesiologist
85	Nurse midwife
86	OB/GYN nurse practitioner
88	Orthodontist
90	Occupational therapist
91	Physical therapist
92	Speech therapist
93	Respiratory therapist
95	Aged/disable waiver
96	Develop services waiver
97	Channeling waiver
98	Comm supp living arrangement
99	Other