Dear Provider:

Thank you for your interest in participating as a provider of medical services for programs administered by the U.S. Department of Labor's Office of Workers' Compensation Compensation Programs (OWCP). The OWCP administers the Federal Employees' Compensation Act (FECA), the Black Lung Benefits Act (BLBA), and the Energy Employees Occupational Illness Compensat ion Program Act (EEOICPA).

OWCP has contracted with Affiliated Computer Servic es (ACS) to provide medical bill processing services to those three 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.

To process your bills, each provider must be enrolled with ACS. Please complete the enclosed provider enrollment form so that a provider identification number can be assigned to you. Instructions for completing the enrollment form and a list of provider types and specialty codes are also included.

The Debt Collection Improvement Act of 1996 includes the requirement that payments made by the Federal Government be sent by electronic funds transfer (EFT). EFT payments simplify and speed the billing process and reduce the incidence of billing errors. Therefore, 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.

You must submit current licensure information on the completed enrollment application. Moreover you must maintain appropriate current licensure in order to receive payments under our programs. 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 their entire group.

You may register as a participant in any or all three of OWCP's compensation programs. Please be sure to send the completed package(s) to the appropriate program(s) at the address (es) listed on P. 2 of the Form OWCP-1168.

Please be aware that OWCP, in an effort to assist claimants seeking medical services, is now providing an on-line search capability by one or more of the following: specialty, name, city, state, and zip code. The provider look up feature is meant as a customer service feature for those who may be seeking certain medical services in their area. [The FECA program provides search capability for physicians enrolled in their program . In addition to physicians, the EEOICPA program is providing a search capability for home health aides and hospice care.

FBLP will include all provider types for the provider look-up with the exception of provider type 53, non-medical vendors from the search.

Please advise us in writing when you submit your enrollment application if for some reason you do not wish to be included in this service. Customers using this look-up feature will be advised that this is not an endorsement, referral or an agreement to reimburse for medical services rendered, as the fact that a provider is listed in no way constitutes an endorsement of the provider or that provider's services by the Department of Labor and OWCP. Nor does it guarantee that the medical provider will be reimbursed by OWCP for specific medical services that the provider has billed directly to OWCP or that a medical provider will agree to provide medical services to a particular claimant. The appearance of a specific medical provider's name in the listing of providers in a certain specialty does not require that provider to treat a particular claimant, even if OWCP has already advised the claimant in writing that medical treatment for a particular condition within the provider's listed specialty has been authorized.

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

US Department of Labor
OWCP/FECA
P.O. Box 8300
London, KY 40742-8300

DEEOIC
P.O. Box 8304
London, KY 40742-8304

DCMWC/Black Lung
P.O. Box 8302
London, KY 40742-8302

If you have any questions regarding this information, please contact us at: 1-850-558-1818. Our business hours are Monday through Friday from 8:00 am to 8:00 pm, Eastern Time.

NOTICE: Please be aware that continued participation as a medical provider under the three DOL programs above is contingent on your maintaining good standing as a medical provider under other federal health benefit programs such as an Medicare—exclusion as a medical provider in those circumstances operates as an automatic exclusion under the above-entitled programs administered by OWCP. (See e.g. 20 C.F.R. §§ 10.815, 30.715 and 702.431)

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 or OWCP at the telephone numbers indicated on the form.

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, "b" for a facility, or "c" for a group practice. If you checked "c" (group practice), fill out the appropriate parts of Block 10c on the reverse 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, license number and State, expiration date of current license, speciality code or codes from the list below, and the date any certification expires). Continue on a separate sheet if necessary.
Block 11a	If you checked "a" or "b" (individual practice or facility) in Block 10, 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	Blocks 13a thru 13c are required for hospitals only.
Block 13a	If you checked "b" (facility) in Block 10, type or print your Medicare number.
Block 13b	Type or print your National Provider Identifier (NPI). If you are a medical provider and you do not have an NPI, you can apply for one via the web at https://nppes.cms.hhs.gov. You can also apply via paper enrollment form CMS-101114. The completed form should be sent to: NPI Enumerator P.O. Box 6059 Fargo, ND 58108-6059
Block 13c	Type or print the taxonomy or taxonomies that correspond to the NPI you have entered. This is required for medical providers who have an NPI. You should use the taxonomy values that you submitted when applying for your NPI. More information on provider taxonomy is available at www.wpc-edi.com/taxonomy.

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 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.

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Provider Enrollment Form

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

OMB Number 1215-0137
Expires: 01/31/2010

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? If update, enter Provider Number or EIN: ☐ New enrollment ☐ Update

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 Number	11b. Provider Type

11c. If you select "Other Provider" (96) or Non-Medical Vendor (53), please explain:

12. Tax ID: EIN	SSN

13. Required for hospitals only: 13a. Medicare Number

13b. NPI: 1.	13c. Taxonomy Code(s): 1.
2.	2.
3.	3.

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. United Mine Workers' of American (UMWA) 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 32317-4600	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: 1-866-335-8319	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**

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

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
29	Physician Assistant
30	Advanced Registered Nurse Practitioner (ARNP)
31	CRNA
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)

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
88	Orthodontist
90	Occupational therapist
91	Physical therapist
92	Speech therapist
93	Respiratory therapist
99	Other

PAYMENT INFORMATION FORM
ACH VENDOR PAYMENT SYSTEM

This form is used for the ACH payments with an addendum record that carries payment-related information. Recipients of these payments should bring this information to the attention of their financial institution when presenting this form for completion.

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	
Provider #:	
Name:	
Address:	
Contact Person Name:	Telephone Number:

AGENCY INFORMATION	
Name: DOL Federal Black Lung Program	
Address: PO Box 13200	
Tallahassee, Florida 32317-3200	
Contact Person Name:	Telephone Number: 1-800-638-7072 Toll Free

FINANCIAL INSTITUTION INFORMATION	
Name:	
Address:	
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:

Please return complete forms via Mail or FAX to: (**850) 201-1718**
DOL Federal Black Lung Program, PO Box 13200, Tallahassee, FL 32317-3200
(Incomplete forms will cause a delay in processing and are subject to return).