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?
   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 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	Federal Black Lung Program P.O. Box 828 Lanham—Seabrook, Maryland 20703 - 0828	ACS P.O. Box 14600 Tallahassee FL 32137-4600	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

Form OWCP-1168
Rev. June 2004

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).

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, specialty 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	If you checked "b" (facility) in Block 10, type or print your Medicare number (for 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.

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.
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 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

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Provider Specialty Codes (Blocks 10c and 14d)

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