September 10, 2003

Dear Provider:

Thank you for your participation as a provider for the U.S. Department of Labor, Office of Workers’ Compensation Programs (OWCP).

The OWCP administers the Federal Employees’ Compensation Act (FECA), the Coal Mine Workers’ Compensation Program (DCMWC), the Energy Employees Occupational Illness Compensation Program (EEOICPA) and the Longshore and Harbor Workers’ Compensation Program (LSHWC). As part of their benefit structure, these four programs reimburse both, medical and non-medical providers for services rendered for the care and treatment of a claimant’s compensable condition.

OWCP has contracted with Affiliated Computer Services (ACS) to provide medical bill processing services to the four programs. Each program will be phased in over the next two years beginning with the Federal Employees’ Compensation program later this year. Providers of services to DFEC should continue to bill the program at the London, Kentucky address listed below. Providers of services to the other OWCP programs should continue sending bills directly to those programs.

To process your bills, each provider MUST BE ENROLLED with ACS. Please complete the enclosed provider enrollment form so that a provider I.D. number can be assigned to you. Effective July 26, 1996 the Debt Collection Improvement Act of 1996 MANDATES that payments made by the Federal Government be sent by electronic funds transfer (EFT) therefore, an enrollment form for EFT is also enclosed. A Remittance Advice listing all bills paid on each EFT transaction will continue to be sent to your mailing address.

In addition to the provider and EFT enrollment forms enclosed are instructions for completing the enrollment form, a list of provider types, a list of provider specialty codes and an Electronic Data Interchange (EDI) form should you choose to bill electronically.

Please send the completed package to:

Affiliated Computer Services (ACS)
Enrollment Unit
Department of Labor
PO Box 14600
Tallahassee, FL 32317-4600
If you are a physician, you **MUST** submit copy of your license along with the enrollment application.

Once your enrollment package has been processed, you will be notified by mail in approximately two weeks. During the transitional period, please continue to submit your bills to:

US Department of Labor
OWCP
PO Box 8300
London, KY 40742-8300

Please do not hesitate to contact our toll-free number at 1-866-335-8319 Monday through Friday from 8:00 am to 8:00 pm Eastern Standard Time, if you have any questions on this material.
Provider Enrollment Form

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
   - Individual
   - Facility (For Individual or Facility, complete indicated sections below)
   - 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

13. SSN

14. 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
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.

<table>
<thead>
<tr>
<th>Name</th>
<th>SSN #</th>
<th>Prov Type Code</th>
<th>License #/ State</th>
<th>Current Lic# Exp Date</th>
<th>Specialty Code(s)</th>
<th>Certification Exp Date</th>
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</tr>
</tbody>
</table>

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:
ACS
P.O. Box 14600
Tallahassee, FL 32317-4600

For Black Lung Program:
DOL Black Lung Program
P.O. Box 13200
Tallahassee, FL 32317-3200

For Energy Program:
DOL Energy Program
P.O. Box 13400
Tallahassee, FL 32317-3400

For Longshore Program:
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

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 “a” or “b” (individual practice or 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 If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your United Mine Workers of America (UMWA) number, if any.

Block 16a If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your billing street address. This is where your Remittance Advices and paper checks will 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 If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your billing city.

Block 16c If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your billing State.

Block 16d If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your billing zip code (all nine digits).

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)**

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 10cd and 14d)

<table>
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<tr>
<th>Code</th>
<th>Specialty</th>
<th>Code</th>
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<td>Adolescent Medicine</td>
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<td>Rheumatology</td>
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<tr>
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<td>Allergy</td>
<td>52</td>
<td>Abdominal surgery</td>
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<td>Anesthesiology</td>
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<td>Cardiovascular surgery</td>
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<tr>
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<td>Cardiovascular Disease</td>
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<td>Colon and rectal surgery</td>
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<td>Dermatology</td>
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<td>General surgery</td>
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<td>06</td>
<td>Diabetes</td>
<td>56</td>
<td>Hand surgery</td>
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<tr>
<td>07</td>
<td>Emergency Medicine</td>
<td>57</td>
<td>Neurological surgery</td>
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<tr>
<td>08</td>
<td>Endocrine Medicine</td>
<td>58</td>
<td>Orthopedic surgery</td>
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<tr>
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<td>Family Practice</td>
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<td>Gastroenterology</td>
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<td>Infectious Diseases</td>
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<td>Obstetrics and Gynecology</td>
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<td>Geriatric nurse practitioner</td>
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