U. S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS COMPENSATION PROGRAMS
DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL
ILLNESS COMPENSATION
WASHINGTON DC 20210

November 17, 2004

Dear Sir or Madam:

Thank you for your interest in enrolling as a provider in the U.S. Department of Labor's (DOL) Energy Employees Occupational Illness Compensation Program (EEOICP). The Division of Energy Employees Occupational Illness Compensation (DEEOIC) provides benefits to eligible current or former employees of the Department of Energy (DOE), its contractors and subcontractors. To be eligible, an employee must have been diagnosed with a radiogenic cancer, chronic silicosis, beryllium sensitivity, or chronic beryllium disease and employed at a DOE covered facility, atomic weapons employer or beryllium vendor facility during a specific period of time.

Under the EEOICP, once a claimant is found to be eligible for medical benefits, he/she is issued a letter that identifies the accepted condition(s) and describes medical coverage. Medical coverage includes payment for reasonable and customary expenses that are recommended by a qualified physician and are related to the treatment of the accepted condition(s). Our fee schedule will be based on the location of service. Relative Value Units with geographical modifiers based on Centers for Medicare & Medicaid Services (CMS) data can be reviewed at the Department of Labor's website, **http://www.dol.gov/esa/owcp_org.htm.** To facilitate the processing of medical bills submitted on behalf of an eligible employee, a provider must be issued a unique nine-digit provider identification number.

Each of our eligible claimants will be provided with a medical benefits identification card. On this card, accepted ICD-9 codes are listed for billing purposes. Under our program, the claimant has no out-of-pocket expenses and therefore should not be charged any copay or deductible fees. The claimant's name is listed on this medical benefits identification card, along with our billing address and a toll-free number for billing questions.

Attached is a provider enrollment form for you to complete so that a provider number can be assigned to your facility. The provider enrollment form must be signed by an authorized representative of your firm. DOL is unable to accept a mailing address if it is listed only as a P.O. Box; thus please ensure that a street address is included on the form. **If you are a physician (M.D. or D.O.), you must submit a copy of your medical license along with your enrollment application.**

The Debt Collection Improvement Act of 1996 mandates that payments made by the Federal Government must be sent by electronic funds transfer (EFT). Due to this law, an enrollment form for EFT is also enclosed for your completion. Once a submitted bill has been approved for payment, the U.S. Treasury Department will send payments by EFT directly to your bank account for medical services you have rendered to EEOICP claimants.

Mail your completed enrollment form, EFT forms, and a copy of your medical license to:

EEOICP
Enrollment Unit
P.O. Box 13400
Tallahassee, Fl. 32317-3400

You may also fax your provider enrollment forms and medical license to (850) 201-1718. Please do not bill EEOICP until you have received your unique nine-digit provider number. Once you have received your provider identification number, please mail your medical bills to:

Energy Employees Occupational Illness Compensation Program
P.O. Box 8304
London, KY 40742-8304

When your provider enrollment forms have been processed, you will be notified by letter of your provider identification number.

After you have submitted a bill, you will receive Remittance Vouchers listing all bills paid on each EFT transaction. We have a toll free number, **(**866) 272-2682, for your

billing inquiries. The hours of operation for this toll free number are 8:00 A.M. – 8:00 P.M. (Eastern Standard Time).

You may also elect to submit your bills electronically using Electronic Data Interchange (EDI). You may obtain the EDI enrollment form on-line at **http//:owcp.dol.acs-inc.com.** For your convenience, we are attaching the EDI Enrollment Form, as well as the Department of Labor Trading Partner Agreement. **Note: To submit bills electronically, a minimum submission of 200 bills per month is required.** If you decide to use paper claims, all bills must be submitted using the standard HCFA 1500 (or the OWCP 1500) or UB 92 forms.

You can view and print Remittance Vouchers electronically. For access to this feature, you must complete the EDI Enrollment Form and the Department of Labor Trading Partner Agreement. For your convenience, we are enclosing these forms for your use. There is no minimum number of bills to be submitted for this access. You can also view your three most current Remittance Vouchers online at **http//:owcp.dol.acs-inc.com.** This service is available without submission of the EDI Enrollment Form. You will need your new 9-digit provider number, tax ID, and zip code or license number to create a unique user ID and password online.

Some services will require prior authorization. To obtain an authorization, use our medical bill pay website, **http//:owcp.dol.acs-inc.com**. You may also request an authorization by fax using the attached authorization templates for general medical services, durable medical equipment, or physical therapy / occupational therapy. These requests should be faxed to 1-800-882-6147.

To assist you in your billing, we are enclosing some helpful hints. If you should have any questions, do not hesitate to contact us at (866) 272-2682. We look forward to our continued relationship in providing benefits to our claimants.

Sincerely,

Department of Energy Employees' Occupational Illness Compensation
ACS – Provider Enrollment Unit

Enclosures: Provider enrollment form and instructions
Helpful hints for billing
EFT (ACH) Vendor Payment form and instructions
EDI Enrollment Form
Department of Labor Trading Partner Agreement
Instructions for Completing the OWCP-1500 Form
Instructions for Completing the UB-92 Form

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

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
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