Ohio | Bureau of Workers' Compensation

Application for Provider Enrollment-Non Certification

Provider Enrollment Application (certification not required) MEDCO-13A

The first step to becoming enrolled is to complete the *Application for Provider Enrollment* (MEDCO-13A). This form is only applicable to providers who are not required to become BWC certified (see Medco-13 application if your provider type is not listed in section 1.) **Note to pharmacy providers:** Pharmacies must apply directly with BWC's current pharmacy benefits manager (PBM) to be issued a BWC provider number. Our current PBM is Catamaranrx. You may contact it through email at provider.contracting@catamaranrx.com or at www.sxc.com/pharmacies, or call 877-633-4701, and request enrollment for the Ohio Bureau of Workers' Compensation.

We review all applications to ensure providers meet the minimum enrollment criteria. Providers must meet all licensing, certification or accreditation requirements necessary to provide services. We base minimum credentials for providers are based on provider type.

Have questions? Call 1-800-644-6292, and listen to the options to reach BWC's provider relations department between 8 a.m. and 5 p.m. weekdays.

- Return the completed **Medco-13A** to:
  BWC Provider Enrollment
  P.O. Box 15249
  Columbus, OH 43215-0249
  Fax 614-621-1333

Important reminders

Authorized signature required on each application.
Please include the following with your application, if applicable:

- Internal Revenue Service form W-9; http://www.irs.gov/pub/irs-pdf/fw9.pdf;
- Workers' compensation coverage policy;
- National provider identification verification from Fox Systems Inc.;
- Rehab plan or license/accreditation information.

Visit us on the Internet at:
www.bwc.ohio.gov

Application for Providers to Enroll (BWC certification not required)

Section 1 – Provider type

Select the type that best describes you and submit attachments required for that particular type.

Check one of the following and attach required documents.

- ☐ **12** Group practice – (must attach the name(s) of the BWC-certified member(s), also submit a W-9)
  _____
  _____
- ☐ **40** Hotel/motel – approved rehab plan required
- ☐ **78** University and college (rehab-formal training, including books and supplies) - services must be part of an approval rehab retraining program-rehab plan required
- ☐ **79** Rehabilitation – non-credentialed services – approved rehab plan required
- ☐ **80** Retail store (rehab) – approved rehab plan required
- ☐ **81** Rehabilitation – unsupervised conditioning facility – approved rehab plan required
- ☐ **83** Rehab transportation (taxis, buses and air travel) – approved rehab plan required
- ☐ **99** Interpreter - CSS or rehab plan approval

Section 2 – General information

MEDCO-13A

1 Current BWC provider number *(if known)*

2 National provider ID number (attach Fox Systems Inc. verification)

3 Taxonomy code(s) (attach Fox Systems Inc. verification)

4 Group/business name and dba name *(If applicable)*

5 Tax identification number *(Attach a copy of the IRS form W-9. This number will be used for IRS purposes)*

6 Legal name associated with tax identification number *(Must appear as recognized by the IRS)*

7 Business type

☐ Individual ☐ Sole proprietor ☐ Partnership ☐ Corporation ☐ S Corporation ☐ LLC ☐ Non-profit

8 Owner name(s); define percentage of ownership interest per owner

9 Individual provider name *(applicable only for provider types 79 and 99)* ☐ Male ☐ Female

10 Social Security number *(Individual must provide Social Security number or individual tax identification number.)*

11 Workers' compensation employer policy number, required if you have employees (attach copy of Workers' Compensation Certificate) ☐ Check here if business has no employees

12 Indicate the address where you render services, including suite, floor, etc. We cannot accept PO Box only for practice location.

13 City

14 State | Nine-digit ZIP code

15 Telephone
( )

16 Fax
( ) | Business e-mail address

17 Reimbursement address *(Indicate the address to which we should send all payments, if different from practice address. Include suite, floor etc., street address or P.O. Box.)*

18 City

19 State | Nine-digit ZIP code

20 Correspondence address *(Indicate the address to which we should send all correspondence, if different from practice address. Include suite, floor etc., street address or P.O. Box.)*

21 City

22 State | Nine-digit ZIP code

23 Pharmacy NCPDP number

24 License/accreditation number, expiration date *(If applicable, please attach a copy)*

25 Contact person *(Person completing form)* | Title

26 Telephone number
( ) | Fax number
( ) | E-mail address

Any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to a felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

27 Applicant or authorized personnel signature ***(Required)*** | Title

28 Please print or type name | Date