Ohio | **Bureau of Workers' Compensation**

30 W. Spring St.
Columbus, OH 43215-2256

Request to Change Provider Information

Instructions

- **Please print or type.**
- **Return completed form to: Ohio Bureau of Workers' Compensation, Provider Enrollment Unit, P.O. Box 15249, Columbus, OH 43215-0249, or submit by fax: 614-621-1333**

Questions?

Call **1-800-644-6292** to reach BWC's provider relations department

Points to review before completing this form

- You must determine if you are updating an individual person's provider number or a business/organizational provider number, and complete a separate form for each number to be updated. Submit National Provider Identifier (NPI) verification if applicable.
- Business/Organization providers:
  - If you have a new tax ID without change of ownership, complete this form and send us a new W-9 Internal Revenue Service (IRS) form for our records. This form is found at **www.irs.gov/pub/irs-pdf/fw9.pdf.** Include the date former number became invalid, and the date new number became effective. (Note: no bills will be payable for dates of service after the termination date of the previous provider number).
  - If you are new owners of a tax ID already established in our database, please complete a new provider application (MEDCO-13 or MEDCO-13A) for our files to show authorized agreement signature and ownership information. You do not need to complete this form.

Date effective	New tax identification number ☐ or Social Security number ☐ *(Attach a copy of the IRS form W-9. This number will be used for IRS purposes).*
Legal name associated with tax identification number *(Must appear as recognized by the IRS)*	
DBA name of group/business or individual provider name	
Business type ☐ Individual ☐ Sole proprietor ☐ Partnership ☐ Corporation ☐ S Corporation ☐ LLC ☐ Non-profit	
NPI number *(attach Fox Systems, Inc. verification)*	Taxonomy code *(attach Fox Systems, Inc. verification)*

Previous demographic information

Current BWC provider number	Date no longer valid	
Previous owner name(s)		
Practice location street address *(Indicate the address where you render services, including suite, floor, etc. We will accept a P.O. Box only if you include additional street address information.)*		
City, State, ZIP code		
Telephone ( )	Fax ( )	E-mail address
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.)*		
City, State, ZIP code		
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.)*		
City, State, ZIP code		

New information

New owner name(s)		
Practice location street address *(Indicate the address where you render services, including suite, floor, etc. We will accept a P.O. Box only if you include additional street address information.)*		
City, State, ZIP code		
Telephone ( )	Fax ( )	E-mail address
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.)*		
City, State, ZIP code		
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.)*		
City, State, ZIP code		

Applicant or authorized personnel signature ***(Required)*** Reimbursement change information requires provider's signature	Title
Please print or type name	Date