Bureau of Workers' Compensation

Application for
Provider Enrollment-Non Certification

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

Providers who wish to enroll with BWC but do not have to be BWC certified should complete this form. Important: If your provider type is not listed in Section 1, you must complete the MEDCO-13 form.

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 on provider type.

Note to pharmacy providers: Pharmacies must apply directly with BWC's current pharmacy benefits manager (PBM) to receive a BWC provider number. Our current PBM is Change Healthcare. You may email PBA_WCHelpDesk@changehealthcare.com or call 888-292-5229 to request enrollment for the Ohio Bureau of Workers' Compensation. Ohio pharmacies must have Ohio workers' compensation coverage.

Have questions? Call 1-800-477-2292 to reach BWC's provider relations department between 8 a.m. and 5 p.m. weekdays.

Important reminders

Authorized signature required on each application.
Include the following with your application, if applicable.

- Internal Revenue Service form W-9.
- Workers' compensation policy.
- National provider identification verification from National Plan & Provider Enumeration System (NPPES).
- Rehab plan or license/accreditation information.

Return the completed **MEDCO-13A** to:
BWC Provider Enrollment
P.O. Box 15249
Columbus, OH 43215-0249
Fax: 614-621-1333
Email: Providerenrollment@bwc.ohio.gov

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

Section 1 – Provider type

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

Note: Obtain copy of approved rehab plan from the managed care organization.

- ☐ **12** Group practice – Must attach the name(s) of the BWC-certified member(s), and also submit a W-9.

  _____

  _____

  (NOTE: Group practices having the same tax ID and same NPI are enrolled in the same record listing all additional addresses. If the group practice has separate tax IDs and/or NPIs complete a separate application.)
- ☐ **78** University and college (rehab-formal training, including books and supplies); Services must be part of an approved 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/Other – CSS or rehab plan approval

Section 2 – General information

MEDCO-13A

1	Current BWC provider number (if applicable)	Tax identification number (business)	Social Security number (individual)
2	Individual name (for types 79 & 99) or Business legal name (Business name must appear as recognized by the IRS and on submitted W-9.)		
3	Business - Doing Business As (DBA) name (must appear as recognized by the IRS and on submitted W-9)		
4	Business type (check one - **must match W-9 submitted**) ☐ Individual ☐ Sole proprietor ☐ Business (Corporation, LLC, S-Corp, Single member LLC, Partnership, Non-profit, etc.)		
5	NPI number	Taxonomy code(s)	
6	Business owner name(s), define 100% of ownership, designate interest amount per owner. **If more than two owners, use separate page below.**		
7	☐ Check if no employees	Workers' compensation policy number (**required** if you have employees)	
8	Practice location street address *(Indicate the address where you render services, including suite, floor, etc. Do not use P.O. box.)* **List additional addresses on separate page below.**		
9	City	State	Nine-digit ZIP code
10	Telephone number **(required)**	Fax	
11	Email for office/provider **(required)**		
12	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.)*		
13	City	State	Nine-digit ZIP code
14	Correspondence address *(Indicate the address to which we should send all correspondence, if different from practice address. Include suite, floor etc., street address or*		
15	City	State	Nine-digit ZIP code
16	Rehab plan attached - ☐ Yes ☐ No (Obtain from MCO).	List BWC claim number	MCO name/contact information

	Requirement/Credentials	Effective date	State	Number	Expiration
17	Pharmacy NCPDP number				
18	License #1				
19	Other				

20	Contact person (Person completing form)		Title
21	Telephone number **(required)** ( )	Fax number ( )	Email 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, and may be terminated from participation in the BWC's Health Partnership Program.

22	Applicant or authorized personnel signature **(required)**	Title
23	Print or type name	Date

BWC USE ONLY

Online account username

	Owner name	Ownership%
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Additional practice address - Only permitted for type 12, group practices

Street address		
City	State	ZIP code
County	Telephone **(required)**	Fax number
Office email		

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