HEALTH PARTNERSHIP PROGRAM

Application for

Provider Enrollment and Certification

MEDCO-13

BWC
Better Workers' Compensation
Built with *you* in mind

To provide quality health care to Ohio's injured workers at a reasonable cost, the Ohio Bureau of Workers' Compensation (BWC) implemented the Health Partnership Program (HPP), a managed care program mandated by House Bill 107.

The first step to becoming BWC certified is to complete the *Application for Provider Enrollment and Certification* (MEDCO-13).

BWC reviews all applications to ensure providers meet the minimum certification criteria. Providers must meet all licensing, certification or accreditation requirements necessary to provide services. BWC bases other minimum credentials for a provider on the provider type.

Once the certification process is completed, BWC will include your name on the Certified provider look-up on its Web site, **ohiobwc.com.** BWC also will provide your name to the managed care organizations (MCOs) responsible for medically managing BWC's workers' compensation claims.

In addition, all providers must complete the attached required *Declaration Regarding Material Assistance/Nonassistance to a Terrorist Organization* for Government Business and Funding Contracts as required by Ohio Revised Code 2909.33. You should complete this form after viewing the U.S. Department of State Terrorist Exclusion List located at:
http://www.homelandsecurity.ohio.gov/dma_terrorist/terrorist_exclusion_list.pdf

Have questions?
Call 1-800-OHIOBWC,
and listen to the options to reach
BWC's Provider Relations department,
between 8 a.m. and 4:30 p.m. weekdays.

Visit us on the internet at:
ohiobwc.com

Completing the MEDCO-13
- Please print or type.
- Please complete one application/agreement per federal tax identification number or practice location.
- Complete a separate application/agreement for each individual member of a group physician practice.
- Return the completed application/agreement to:
  BWC Provider Enrollment
  P.O. Box 182031
  Columbus, OH 43218-2031
  Fax (614) 995-2249

Important reminders

Authorized signature required on each application/agreement
Please include the following with your application/agreement, if applicable:
- State license with number and expiration date, certificate or accreditation;
- American or National Board certificate, if applicable;
- Professional liability insurance (malpractice) coverage sheet, if applicable;
- Drug Enforcement Administration registration, if applicable;
- Internal Revenue Service form W-9;
- Workers' compensation coverage policy.

Application for Provider Enrollment and Certification

Section 1 – Provider Type

Check the type number that best describes your provider type and complete sections requested for that particular type.

- ☐ **12** Group practice – If you are a group practice, a partnership registered with the Internal Revenue Service (IRS) under a different name or incorporated, complete sections 2 and 5 for each tax identification number and/or practice address.

If you check one of the following, complete sections 2,3,4 and 5 and attach requested documents. Malpractice insurance required.

- ☐ **09** Physician (DC)
- ☐ **15** Dentist (DDS)
- ☐ **33** Advanced practice nurse (clinical nurse specialist and certified nurse practitioner) – ANCC certified equivalent and Certificate of Authority from State Nursing Board
- ☐ **38** Mechanotherapist (DMT)
- ☐ **52** Nurse anesthetist – AANA or CRNA certification and Certificate of Authority from State Nursing Board
- ☐ **59** Optometrist (OD)
- ☐ **66** Physician (DO)
- ☐ **67** Physician (MD)
- ☐ **70** Podiatrist (DPM)
- ☐ **72** Psychologist (PhD)
- ☐ **84** (Licensed) Professional counselor and (Licensed) social worker – State Counselor and Social Worker Board license
- ☐ **88** (Licensed) Professional clinical counselor and (Licensed) independent social worker – State Counselor and Social Worker Board license

If you check one of the following, complete sections 2, and 5 and attach the requested documents.

- ☐ **01** Air ambulance – FAA pilot license and paramedic training certificate Private = State ambulance Board license. Government = Medicare certification
- ☐ **02** Ambulance service – Private = State Ambulance Board license. Government = Medicare certification
- ☐ **03** Ambulatory surgery center – Ohio Department of Health license
- ☐ **04** Audiologist – State Board of Speech Pathology and Audiology license and Certificate of Clinical
- ☐ **05** Non-physician acupuncturist – Applicable State Medical Board Registration
- ☐ **10** Clinic - drug/alcohol (free standing) – State Department of Alcohol and Drug Addiction Services certification
- ☐ **11** Clinic - pain (free standing) – CARF accreditation
- ☐ Non-CARF accredited facilities Application addendum will be required
- ☐ **14** Physician assistant – NCCPA certification and Certificate of Registration from State Medical Board
- ☐ **16** Dialysis center/ESRD clinic (free standing) – State Health Department certificate
- ☐ **17** Durable medical equipment supplier – State vendor's license – Medicare certification or JCAHO accreditation
- ☐ **27** Hearing aid dealer/Dispenser – State Hearing Aid Dealers and Fitters Board license
- ☐ **28** Certified shoe retailer – Prescription Footwear Association certification
- ☐ **30** Home health agency – Medicare certification, JCAHO accreditation or CHAP accreditation
- ☐ **34** Hospital – general/acute – JCAHO accreditation or AOA accreditation or Medicare certification
- ☐ **35** Hospital – drug/alcohol – JCAHO or AOA accreditation or Medicare and Department of Alcohol and Drug Addiction Services certification
- ☐ **36** Hospital – psychiatric – JCAHO accreditation or AOA accreditation or Medicare certification and Department of Mental Health license
- ☐ **37** Hospital rehabilitation – JCAHO, AOA, or CARF accreditation or Medicare certification
- ☐ **40** Hotel/Motel – (must be associated with a rehab or chronic pain facility) approved rehab plan required
- ☐ **45** Laboratory – HCFA CLIA certification
- ☐ **48** Massage therapist/Massotherapist – State Medical Board license
- ☐ **53** Nursing home – State Health Department license, Medicaid certification or residential care/assisted living facility – State Health Dept. License; Medicaid Certification
- ☐ **57** Occupational therapist – State Occupational Therapy, Physical Therapy and Athletic Trainers Board license
- ☐ **58** Optician – State Optical Dispensers Board license
- ☐ **64** Pharmacy – Terminal Distributor license from the State Pharmacy Board, electronic point of sale eligibility
- ☐ **65** Physical therapist (LPT) – State Occupational Therapy, Physical Therapy and Athletic Trainers Board license
- ☐ **68** Athletic trainer – License from the State Occupational Therapy, Physical Therapy and Athletic Trainers Board
- ☐ **71** Prosthetist/Orthotist (CO, CP, COP) – Prosthetist-American Board Certified, Orthotist-American Board certification or Board Orthotist certification
- ☐ **75** Radiology services – State Health Department Certificate of Registration
- ☐ **76** Rehabilitation – vocational case management – COHN, CRC, CRRN, CVE, CDMS or CCM credentials
- ☐ **78** Universities and colleges (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 stores (Rehab) – Approved rehab plan required
- ☐ **81** Rehabilitation – unsupervised conditioning facility – approved Rehab Plan required
- ☐ **82** Rehabilitation – traumatic brain injury facility – CARF accreditation
- ☐ **83** Rehab transportation (taxis, buses and air travel) – Approved rehab plan required
- ☐ **87** Rehabilitation – voc case management intern – application addendum required and will be sent upon receipt
- ☐ **89** Speech pathologist – State Board of Speech Pathology and Audiology license
- ☐ **90** Ergonomist – CPE; CHFP, AEP, AHFP; CEA; CSP with ergonomics specialist designation; CIE; ATP; or RET
- ☐ **96** Urgent care center – JCAHO accreditation

SECTION 2 – General Information

Current BWC provider number *(if known)*

Group/business name or dba name *(if applicable)*

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

Name associated with tax identification number *(Must appear as recognized by the IRS)*

Business type

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

Owner name

Workers' compensation employer policy number

Individual provider name *(first name, middle initial, last name)*

☐ Male ☐ Female

Social Security number *(Individual physicians of a group practice must provide social security number or individual tax identification number)*

Practice location street address *(Indicate the address where services are rendered including suite, floor, etc. **Do not use P.O. Box**.)*

City | State | Nine-digit ZIP code

Telephone ( ) | Fax ( )

Reimbursement address *(Indicate the address to which all payments should be sent, if different from practice address. Include suite, floor etc.) (**Street address or P.O. Box**)*

City | State | Nine-digit ZIP code

Correspondence address *(Indicate the address to which all correspondence should be sent, if different from practice address. Include suite, floor etc.) (**Street address or P.O. Box**)*

City | State | Nine-digit ZIP code

Universal provider ID number *(if applicable)* or Pharmacy NCPDP number *(formerly NABP)*

License number, type and expiration date *(if applicable) (Please attach a copy of license)*

Section 3 – Individual Provider Information

Physician board certification - *(Indicate specialty, date certified and check whether American Board (AB) or National Board (NB). Please attach copy of certification.)*

Primary specialty | Date certified | ☐ AB ☐ NB

Secondary specialty | Date certified | ☐ AB ☐ NB

Drug Enforcement Administration (DEA) number *(if applicable) (Please attach a copy of DEA registration.)*

Date of birth *(Required)*

Provider home address

City | State | Nine-digit ZIP code

Education/training – List all internship/residency and fellowship programs. Attach additional sheet if necessary. Medical or Professional School *(if applicable)*

Institution type	Dates attended	Year graduated	Degree

The following provider types require malpractice insurance coverage – a copy of your professional liability insurance (malpractice) must be submitted with the completed application.

67 Physician (MD)	72 Psychologist
66 Physician (DO)	15 Dentist (DDS)
70 Physician (DPM)	38 Mechanotherapist (DM)
09 Physician (DC)	84 Professional counselor/Social worker
52 Certified registered nurse anesthetist (CRNA)	88 Professional clinical counselor/Independent social worker
59 Optometrist (OD)	33 Advance practice nurse

Section 4 – Provider Information Questions and Answers

Answer the following questions. Please explain any yes answer in the space below. Attach a separate sheet of paper if needed. All yes answers must have a written explanation.

1. Have you ever been, or are you now, dependent on, impaired by, being treated for alcohol or any other drug substance, or do you have any emotional or physical disabilities that may limit your ability to practice? ☐ Yes ☐ No
2. Have you ever had a malpractice judgement entered against you, have any pending suits against you in any court proceeding or arbitration hearing, or have you ever been a party to an out-of-court settlement involving actual or claimed malpractice (submit five-year history)? ☐ Yes ☐ No
3. Have you ever been subject to disciplinary action by any state or local medical society, state board of medical examiners or any other professional organization, Medicare or Medicaid or other health care plan (i.e. HMO, PPO, TPA) or third-party payer, or have you ever had suspended, restricted or denied hospital privileges? ☐ Yes ☐ No
4. Do you have a history of:
   (a) A felony conviction in any jurisdiction; a conviction under a federal controlled substance act; a conviction for an act involving dishonesty, fraud, or misrepresentation; a conviction for a misdemeanor committed in the course of practice; or court supervised intervention or treatment in lieu of conviction pursuant to section 2951.041 of the Revised Code or the equivalent law of another state; ☐ Yes ☐ No

   (b) A conviction or plea of guilty to a violation of sections 2913.48 (workers' compensation fraud) or 2923.31 to 2923.36 (corrupt activity) of the Revised Code; or any other criminal offense related to the delivery of or billing for health-care benefits by the provider, or its owner, or an officer, authorized agent, associate, manager, or employee of the provider; ☐ Yes ☐ No

   (c) An entry of judgment against the provider, or its owner, or an officer, authorized agent, associate, manager, or employee with proof of the specific intent of the provider, or its owner, or an officer, authorized agent; associate, manager, or employee of the provider, in a civil action involving payment by deception brought pursuant to section 4121.444 of the Revised Code; ☐ Yes ☐ No

   (d) An entry of judgment against the provider, or its owner, or an officer, authorized agent, associate, manager, or employee of the provider in a civil action brought pursuant to sections 2923.31 to 2923.36 (corrupt activity) of the Revised Code? ☐ Yes ☐ No
5. Do you refer patients for testing to any facility with which you or an immediate family member have an ownership or investment interest, or a compensation arrangement? ☐ Yes ☐ No
6. I am accepting: new ☐ (or) existing patients only ☐ in my practice

Explanation: _____

Contact person *(person completing form)*		
Telephone number ( )	Fax number ( )	E-mail address

Section 5 – Provider Application/Agreement

By signing this application/agreement, the provider agrees to, and may be decertified pursuant to Ohio Administrative Code (OAC) 4123-6-17 for failure to adhere to the following:

Provider agrees to abide by the Ohio Revised Code (ORC) and rules promulgated thereunder by the Ohio Bureau of Workers' Compensation (BWC) and the Industrial Commission of Ohio. In addition, provider agrees to accept and abide by all billing and/or other policies, procedures and criteria as set forth and amended from time to time in BWC's *Provider Billing and Reimbursement Manual*;

Provider agrees to bill BWC, self-insuring employer, appropriate certified managed care organization (MCO) and/or qualified health plan (QHP), in accordance with the statute of limitations, only for services and items that were actually performed or provided and are medically necessary, cost-effective and reasonably related to the claimed or allowed condition related to the industrial injury/illness. Provider understands BWC, self-insuring employer, appropriate certified MCO and/or QHP does not reimburse for failed or missed appointments (no-shows).

Provider agrees to charge BWC, self-insuring employer, appropriate certified MCO and/or QHP no more than the usual fee billed non-industrial patients for the same service. Provider further agrees not to seek additional payment from the injured worker or employer for the difference between the amount allowed and the provider's billed charge when a provider's fee bill for services or supplies has been approved for payment by BWC, self-insuring employer, appropriate certified MCO and/or QHP.

Provider agrees to assume responsibility for the accuracy of all bills submitted for payment to BWC, self-insuring employer, appropriate certified MCO and/or QHP by provider, or any employee or agent of provider.

Provider agrees to create, maintain and retain sufficient records, papers, books and documents in such form to fully substantiate the delivery, value, necessity and appropriateness of goods and services provided to injured workers under the Health Partnership Plan (HPP) or of significant business transactions, as provided by OAC 4123-6-451. Provider further agrees to make such records available for review by BWC, self-insuring employer, appropriate certified MCO and/or QHP within 30 calendar days or such time as agreed to by the parties, in accordance with OAC 4123-6-45.

The provider affirms that, as applicable to the provider, no party listed in Division (Y) or (Z) of Section 3517.13 of the ORC or spouse of such party has made, as an individual, within the two previous calendar years, one or more contributions totaling in excess of $1,000 to the campaign committee of the Governor of Ohio or lieutenant governor or to the campaign committee of any candidate for the office of governor or lieutenant governor.

Certification Statement
I certify the information submitted by me in this application is true, accurate and complete to the best of my knowledge and belief.

I hereby authorized BWC to consult with persons, companies, governmental authorities, organizations and others who may have any information or documents regarding my character, background qualifications, professional competence and credentials, and I hereby consent to the release of any such information or documents to BWC for purposes of its evaluation of me in connection with the HPP.

I hereby release from liability any such person, company, government authority, organization and others that provide information as part of this credientialing process.

Applicant signature ***(REQUIRED)***	Date
Please print or type name	

Ohio Department of Public Safety
Division of Homeland Security
http://www.homelandsecurity.ohio.gov

GOVERNMENT BUSINESS AND FUNDING CONTRACTS

In accordance with section 2909.33 of the Ohio Revised Code

DECLARATION REGARDING MATERIAL ASSISTANCE/NONASSISTANCE TO A TERRORIST ORGANIZATION

This form serves as a declaration of the provision of material assistance to a terrorist organization or organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List (see the Ohio Homeland Security Division website for a reference copy of the Terrorist Exclusion List).

Any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided. Failure to disclose the provision of material assistance to such an organization or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree.

For the purposes of this declaration, "material support or resources" means currency, payment instruments, other financial securities, funds, transfer of funds, and financial services that are in excess of one hundred dollars, as well as communications, lodging, training, safe houses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation, and other physical assets, except medicine or religious materials.

LAST NAME	FIRST NAME	MIDDLE INITIAL

HOME ADDRESS			
CITY	**STATE**	**ZIP**	**COUNTY**
HOME PHONE	**WORK PHONE**		

COMPLETE THIS SECTION ONLY IF YOU ARE A COMPANY, BUSINESS OR ORGANIZATION

BUSINESS/ORGANIZATION NAME			
BUSINESS ADDRESS			
CITY	**STATE**	**ZIP**	**COUNTY**
PHONE NUMBER			

DECLARATION

In accordance with division (A)(2)(b) of section 2909.32 of the Ohio Revised Code

For each question, indicate either "yes," or "no" in the space provided. Responses must be truthful to the best of your knowledge.

1. Are you a member of an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ Yes ☐ No

2. Have you used any position of prominence you have with any country to persuade others to support an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ Yes ☐ No

GOVERNMENT BUSINESS AND FUNDING CONTRACTS - CONTINUED

3. Have you knowingly solicited funds or other things of value for an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ Yes ☐ No

4. Have you solicited any individual for membership in an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ Yes ☐ No

5. Have you committed an act that you know, or reasonably should have known, affords "material support or resources" to an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ Yes ☐ No

6. Have you hired or compensated a person you knew to be a member of an organization on the U.S. Department of State Terrorist Exclusion List, or a person you knew to be engaged in planning, assisting, or carrying out an act of terrorism?
   ☐ Yes ☐ No

In the event of a denial of a government contract or government funding due to a positive indication that material assistance has been provided to a terrorist organization, or an organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List, a review of the denial may be requested. The request must be sent to the Ohio Department of Public Safety's Division of Homeland Security. The request forms and instructions for filing can be found on the Ohio Homeland Security Division website.

CERTIFICATION

I hereby certify that the answers I have made to all of the questions on this declaration are true to the best of my knowledge. I understand that if this declaration is not completed in its entirety, it will not be processed and I will be automatically disqualified. I understand that I am responsible for the correctness of this declaration. I understand that failure to disclose the provision of material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List, or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree. I understand that any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided by myself or my organization. If I am signing this on behalf of a company, business or organization, I hereby acknowledge that I have the authority to make this certification on behalf of the company, business or organization referenced on page 1 of this declaration.

X _____ _____

Signature Date