

Provider Enrollment and Certification

MEDCO-13

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

Please review the entire application carefully, noting it includes new provisions mandated by changes in the Ohio Administrative Code (OAC), Ohio elections law and by executive order of the governor of Ohio, Ted Strickland.

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

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

In addition, Provider types 76 (Vocational rehabilitation – vocational case management), 87 (Rehabilitation – vocational case management intern) and 90 (Ergonomist) must complete the Declaration Regarding Material Assistance/Non-Assistance to a Terrorist Organization (DMA) certification as required by the Ohio Department of Public Safety/Ohio Homeland Security. These Provider types are required to register at the Ohio Business Gateway, <http://obg.ohio.gov> to certify that the Provider does not provide material assistance to any organization on the United States, Department of State's terrorist exclusion list. Failure to complete the certification by these Provider types may invalidate their Provider Application/Agreement and/or result in suspension of payment until such time as the certification is completed.

Have questions?

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

Visit us on the Internet at:

ohiobwc.com

All provider types are not required to become BWC certified. If you do not find your provider type in Section 1 of the application, please see the Medco-13A form available at ohiobwc.com.

Completing the MEDCO-13

- Please print or type.
- Please complete one application/agreement per federal tax identification number.
- List all practice locations (use separate sheet if needed)
- 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 614-621-1333

Important reminders

Authorized signature required on each application/agreement.

Please include the following with your application/agreement, if applicable:

- State licensure or accreditation/certification document copy with number and expiration date;
- Board or diplomate certificate, if applicable;
- Professional liability insurance (malpractice) coverage sheet, if applicable;
- Drug Enforcement Administration registration, if applicable;
- Internal Revenue Service form W-9; <http://www.irs.gov/pub/irs-pdf/fw9.pdf>;
- Workers' compensation coverage policy;
- National provider ID verification (from Fox Systems, Inc.), if applicable.



Section 1 – Provider Type

Select the type that best describes you and complete sections requested for that particular type.

If you do not find your provider type, see the Medco-13A form available at ohiobwc.com.

If you check one of the following, complete sections 2,3,4 and 5 and attach required documents.	
<input type="checkbox"/> 04 Audiologist – state board of speech pathology and audiology license	<input type="checkbox"/> 59 Optometrist (OD) - state board license
<input type="checkbox"/> 05 Non-physician acupuncturist – applicable state medical board registration	<input type="checkbox"/> 65 Physical therapist (LPT) – state occupational therapy, physical therapy and athletic trainers board license
<input type="checkbox"/> 09 Physician (DC) - state chiropractic board license	<input type="checkbox"/> 66 Physician (DO) - state board license
<input type="checkbox"/> 14 Physician assistant – NCCPA certification and certificate of registration from state medical board	<input type="checkbox"/> 67 Physician (MD) - state board license
<input type="checkbox"/> 15 Dentist (DDS) - state dental board license	<input type="checkbox"/> 68 Athletic trainer – license from the state occupational therapy, physical therapy and athletic trainers board
<input type="checkbox"/> 27 Hearing aid dealer/dispenser – state hearing aid dealers and fitters board license	<input type="checkbox"/> 70 Podiatrist (DPM) - state board license
<input type="checkbox"/> 28 Certified shoe retailer - Prescription Footwear Association certification	<input type="checkbox"/> 71 Prosthetist/orthotist/pedorthist (CO, CP, COP) – license from orthotics, prosthetics and pedorthics board
<input type="checkbox"/> 33 Advanced practice nurse (clinical nurse specialist and certified nurse practitioner) – ANCC certified equivalent and certificate of authority from state nursing board	<input type="checkbox"/> 72 Psychologist (PhD) - state board license
<input type="checkbox"/> 48 Massage therapist/massotherapist – state medical board license	<input type="checkbox"/> 76 Vocational rehabilitation – vocational case management – COHN, CRC, CRRN, CVE, CDMS or CCM credentials
<input type="checkbox"/> 52 Nurse anesthetist – AANA or CRNA certification and certificate of authority from state nursing board	<input type="checkbox"/> 84 (Licensed) Professional counselor and (licensed) social worker – state counselor and social worker board license
<input type="checkbox"/> 57 Occupational therapist – state occupational therapy, physical therapy and athletic trainers board license	<input type="checkbox"/> 88 (Licensed) Professional clinical counselor and (licensed) independent social worker – state counselor and social worker board license
<input type="checkbox"/> 58 Optician – state optical dispensers board license	<input type="checkbox"/> 89 Speech pathologist – state board of speech pathology and audiology license
	<input type="checkbox"/> 90 Ergonomist – CPE; CHFP, AEP, AHFP; CEA; CSP with ergonomics specialist designation; CIH; ATP; or RET

If you check one of the following, complete sections 2, and 5 and attach the required documents.	
<input type="checkbox"/> 01 Air ambulance – private: license from Ohio Medical Transportation Board; public/gov't: Medicare participation	<input type="checkbox"/> 35 Hospital – drug/alcohol – JCAHO accreditation, AOA HFAP accreditation or Medicare participation and Ohio Dept. of Alcohol and Drug Addiction Services certification
<input type="checkbox"/> 02 Ambulance/Ambulette Service – private: license from Ohio Medical Transportation Board; public/gov't: Medicare participation	<input type="checkbox"/> 36 Hospital – psychiatric – JCAHO accreditation, AOA HFAP accreditation or Medicare participation
<input type="checkbox"/> 03 Ambulatory Surgical Center: Ohio Department of Health license and Medicare participation	<input type="checkbox"/> 37 Hospital - Rehabilitation/Long Term Acute Hospital – CARF accreditation, JCAHO accreditation, AOA HFAP accreditation or Medicare participation
<input type="checkbox"/> 10 Clinic - drug/alcohol (free standing) – state department of alcohol and drug addiction services certification	<input type="checkbox"/> 45 Laboratory – CMS CLIA certification
<input type="checkbox"/> 11 Pain clinic - free standing - CARF accreditation; hospital based, CARF or JCAHO accreditation	<input type="checkbox"/> 53 Nursing home – state health department license
<input type="checkbox"/> 16 Dialysis center/ESRD clinic (free standing) – state health department certification and Medicare participation	<input type="checkbox"/> 56 Residential care/Assisted living - state health department license
<input type="checkbox"/> 17 Durable medical equipment supplier - State vendors license, Medicare participation or JCAHO accreditation	<input type="checkbox"/> 75 Radiology services – (free standing) state health dept licensing, registration or accreditation; (mobile) state, county, or city registration, or medicare or medicaid participation
<input type="checkbox"/> 30 Home health agency – Medicare participation, JCAHO accreditation or CHAP accreditation	<input type="checkbox"/> 82 Rehabilitation – traumatic brain injury facility – CARF accreditation
<input type="checkbox"/> 32 (HHA) Hospice - State health department license and Medicare/Medicaid participation	<input type="checkbox"/> 87 Rehabilitation – vocational case management intern – application addendum required and will be sent upon receipt
<input type="checkbox"/> 34 Hospital – general/acute – JCAHO accreditation, AOA HFAP accreditation or Medicare participation	

Section 2 – General information

1 Current BWC provider number <i>(If known)</i>	Business NPI number (attach Fox Systems Inc. verification)	
2 Business name or dba name <i>(If applicable)</i>	Taxonomy code(s) (attach Fox Systems Inc. verification)	
3 Tax identification number <i>(Please attach a copy of the IRS form W-9. This number will be used for IRS purposes)</i>	Name associated with tax identification number <i>(Must appear as recognized by the IRS)</i>	
4 Business type <input type="checkbox"/> Individual <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Non-profit		
5 Owner name(s); define percentage of ownership interest per owner		
6 Workers' compensation employer policy number <i>(Required if you have employees)</i> Attach certificate of coverage.		Check here if no employees <input type="checkbox"/>
7 Individual provider name <i>(First name, middle initial, last name)</i>	Social Security number	<input type="checkbox"/> Male <input type="checkbox"/> Female
8 Individual NPI number (attach Fox Systems Inc. verification)	Taxonomy code(s) (attach Fox Systems Inc. verification)	
9 Practice location street address <i>(Indicate the address where you render services, including suite, floor, etc. Do not use P.O. Box.)</i> Add all additional addresses on separate page.		
10 City	State	Nine-digit ZIP code
11 Telephone ()	Fax ()	E-mail
12 Reimbursement address <i>(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.)</i>		
13 City	State	Nine-digit ZIP code
14 Correspondence address <i>(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.)</i>		
15 City	State	Nine-digit ZIP code
16 Drug Enforcement Administration (DEA) number <i>(if applicable)</i> <i>(Please attach a copy of DEA registration.)</i>		
17 "List all Medicare number(s) as indicated under provider type requirement in Section 1. If hosp. provider type, designate all numbers to matching types (types are: Rehab hosp. medicare number, Psych hosp. medicare number, Acute/General hosp. medicare number, Long Term Acute Care hosp. medicare number).		
18 Medicaid number (as indicated by specific provider type requirements in Section 1 - attach participation verification).		

Section 3 – Individual provider information

American Board or Medical Specialties (ABMS) or American Osteopathic Board - <i>(Attach copy of certificate)</i>				
List all board specialties	Date certified	<input type="checkbox"/> ABMS <input type="checkbox"/> AOA <input type="checkbox"/> Chiropractic Diplomate	Physician declared practice specialty	
Provider home address			Date of birth <i>(Required)</i>	
City	State	Nine-digit ZIP code		
Education/training – List all internship/residency and fellowship programs. Attach additional sheet if necessary. Medical or professional school <i>(if applicable)</i>				
Institution type	Year graduated	Degree/Certification	Certificate/License#	Expiration Date
Please provide foreign languages spoken				

The provider types below require malpractice insurance coverage – you must submit a copy of your professional liability insurance (malpractice) with the completed application (Include covered members list).

- | | | |
|--------------------------------|--|--|
| 05 Non-physician acupuncturist | 52 Certified registered nurse anesthetist (CRNA) | 70 Physician (DPM) |
| 09 Physician (DC) | 59 Optometrist (OD) | 72 Psychologist |
| 15 Dentist (DDS) | 66 Physician (DO) | 84 Professional counselor/social worker |
| 33 Advance practice nurse | 67 Physician (MD) | 88 Professional clinical counselor/independent social worker |
| 38 Mechanotherapist (DM) | | |

Section 4 – Provider information questions and answers

Answer the questions below. Please explain any yes answer in the space below. Attach a separate sheet 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? Yes No
2. Do you have any emotional or physical disabilities or impairments that may limit your ability to practice, or that may jeopardize a patient's health? Yes No
3. Have you ever (submit five-year history) had a malpractice judgment entered against you, have any pending malpractice 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? .. Yes No
4. Have you ever voluntarily surrendered or had your license or certificate to practice suspended, revoked or denied, or subject to restrictions that affect your ability to treat patients, that compromise patient care, or that are related to chemical dependency or substance abuse? Yes No
5. 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? Yes No
6. Have you ever been excluded or removed from participation in Medicare or Medicaid? Yes No
7. Have you ever been excluded or removed from participation in any other health-care plan or third-party payer (i.e. HMO, PPO) for cause? ... Yes No
8. Have you ever had your hospital privileges suspended, restricted, revoked or denied for cause?..... Yes No
9. 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 Ohio Revised Code or the equivalent law of another state (including expunged convictions); 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 Ohio Revised Code; or any other criminal offense related to the delivery of or billing for health-care benefits by the provider, or any person having a five percent or greater ownership interest in the provider, or an officer, authorized agent, associate, manager, or employee of the provider (including expunged convictions); .. 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 any person having a five percent or greater ownership interest in the provider, 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 Ohio Revised Code; Yes No
 - (d) An entry of judgment against the provider, or any person having a five percent or greater ownership interest in the provider, 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 Ohio Revised Code? Yes No
10. Do you refer patients for testing or treatment to any facility with which you or an immediate family member have a five percent or greater ownership or investment interest, or a compensation arrangement?..... Yes No
11. I am accepting: new (or) existing patients only in my practice

Explanation: _____

Contact person (person completing form)		Title
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 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 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*, and all terms of this application/agreement.

Provider agrees to provide health services that are applicable to a work-related injury and not to substantially engage in the practice of experimental modalities of treatment; provide adequate on-call coverage for patients; use BWC-certified providers when making referrals to other providers; and timely schedule and treat injured workers to facilitate a safe and prompt return to work.

Provider agrees to practice in a managed care environment; adhere to MCO and BWC administrative procedures and procedures concerning provider outcome measurement data, peer review, quality assurance, utilization review, billing procedures and dispute resolution subject to OAC 4123-6-16; and report injuries of employees to employers and BWC pursuant to procedures developed by BWC and the MCOs.

Provider agrees to maintain workers' compensation coverage to the extent required under Ohio law or the equivalent law of another state, as applicable. Provider agrees to maintain adequate, current professional malpractice and liability insurance (commercial liability insurance if applicable).

Section 5 – Provider application/agreement (cont.)

Provider agrees to bill BWC, self-insuring employer, appropriate certified (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.

Conflict of interest and ethics law compliance certification

Provider affirms that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict, in any manner or degree, with the performance of services which are required to be performed under this contract. In addition, Provider affirms that a person who is or may become an agent of provider, not having such interest upon execution of this contract shall likewise advise BWC in the event it acquires such interest during the course of this contract.

Provider agrees to adhere to all ethics laws contained in chapters 102 and 2921 of the ORC governing ethical behavior, understands that such provisions apply to persons doing or seeking to do business with BWC, and agrees to act in accordance with the requirements of such provisions; and warrants that it has not paid and will not pay, has not given and will not give, any remuneration or thing of value directly or indirectly to BWC or any of its board members, officers, employees, or agents, or any third party in any of the engagements of this contract or otherwise, including, but not limited to a finder's fee, cash solicitation fee, or a fee for consulting, lobbying or otherwise.

In accordance with Executive Order 2007-01S, provider, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (2) it has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) it will take no action inconsistent with those laws and this order. Provider understands that failure to comply with Executive Order 2007-01S is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the state of Ohio.

Ohio elections law certification (see BWC legal memo attached)

Provider hereby certifies that all applicable parties listed in Divisions (I)(3), (J)(3), (Y)(3) and (Z)(3) of ORC Section 3517.13 are in full compliance with Divisions (I)(1), (J)(1), (Y)(1) and (Z)(1) of O.R.C. Section 3517.13.

Certification statements

I certify the information submitted by me in this application is true, accurate and complete to the best of my knowledge and belief, and that the application is without misrepresentation, misstatement, or omission of a relevant fact, or other acts involving dishonesty, fraud, or deceit.

I hereby authorize 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 credentialing process.

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.

Applicant signature ***(Required)***

Please print or type name