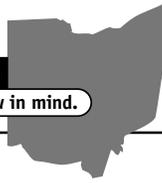




Better Workers' Compensation

Built with you in mind.



# 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 182031, Columbus, OH 43218-2031 or submit by fax: 614-995-2249

**Questions?**

**Call: 1-800-OHIOBWC and follow the options to reach BWC's Provider Relations department**

BWC provider number

PREVIOUS INFORMATION		NEW INFORMATION	
Tax I.D. or Social Security number		New Tax I.D. number <i>(Please attach a copy of W-9)</i>	
Name		Name	
Address <i>(Physical address, cannot use PO Box numbers)</i>		Address <i>(Physical address, cannot use PO Box numbers)</i>	
City, State, ZIP code		City, State, ZIP code	
Telephone number ( )	Telephone number ( )	Fax number ( )	

Previous pay-to address	New pay-to address
Address	Address
City, State, ZIP code	City, State, ZIP code

Previous correspondence address	New correspondence address
Address	Address
City, State, ZIP code	City, State, ZIP code

**Other changes:**

\_\_\_\_\_

\_\_\_\_\_

Provider signature <i>(Required)</i>	Date
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