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).

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

Once the certification process is completed, we will include your name and shareable information on the provider look-up on **www.bwc.ohio.gov**. We also will provide your name to the managed care organizations (MCOs) responsible for managing the medical portion of BWC's workers' compensation claims.

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

Have questions?
Call 1-800-644-6292,
and listen to the options to reach
BWC's provider relations department,
between 8 a.m. and 5 p.m. weekdays.

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 available at www.bwc.ohio.gov.

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.) Note if primary or secondary.
- 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 15249
  Columbus, OH 43215-0249
  Fax: 614-621-1333 or
  Email: Providerenrollment@bwc.state.oh.us

Important requirements

Authorized signature and email 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
- Drug Enforcement Administration registration, if applicable
- Internal Revenue Service (IRS) W-9; http://ee.irs.gov/pub/irs-pdf/fw9.pdf
- Workers' compensation coverage policy
- National Provider Identifier verification (from NPI enumerator), if applicable; proof of acupuncture certificate from Chiropractic Board, if applicable
- Medicare/Medicaid information, if applicable.

Ohio | Bureau of Workers' Compensation

Application for Provider Enrollment and Certification

Section 1 – Provider type

Select the type that best describes you, complete sections requested for that particular type.
If you do not find your provider type, see the MEDCO-13A available at www.bwc.ohio.gov.

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

- ☐ **04** Audiologist – State speech and hearing professional's board license
- ☐ **05** Non-physician acupuncturist – Applicable state medical board license
- ☐ **07** Anesthesiologist assistant – License from state medical board
- ☐ **09** Chiropractor (DC) – State chiropractic board license; state board acupuncture certificate, if applicable
- ☐ **14** Physician assistant – NCCPA certification and license to practice from OSMB
- ☐ **15** Dentist (DDS) – State dental board license
- ☐ **20** Ocularist – State vision professional's board license
- ☐ **27** Hearing aid dealer/dispenser – State speech and hearing Professional's board license
- ☐ **28** Certified shoe retailer – Pedorthic Footwear Association certification
- ☐ **33** Advanced practice nurse (clinical nurse specialist and certified nurse practitioner) – ANCC certified equivalent and certificate of authority from state nursing board
- ☐ **48** Massage therapist/massotherapist – State medical board license
- ☐ **52** Nurse anesthetist – AANA or CRNA certification and certificate of authority from state nursing board
- ☐ **57** Occupational therapist – State occupational therapy, physical therapy, and athletic trainer's board license
- ☐ **58** Optician – State vision professional's board license
- ☐ **59** Optometrist (OD) – State vision professional's board license
- ☐ **65** Physical therapist (LPT) – State occupational therapy, physical therapy, and athletic trainer's board license
- ☐ **66** Physician (DO) – State board license
- ☐ **67** Physician (M.D.) – State board license
- ☐ **68** Athletic trainer – License from the state occupational therapy, physical therapy, and athletic trainer's board
- ☐ **70** Podiatrist (DPM) – State board license
- ☐ **71** Prosthetist/Orthotist/Pedorthist (CO, CP, COP) – License from OHIO OT, PT, AT board
- ☐ **72** Psychologist (PhD) – State board license
- ☐ **76** Vocational rehabilitation – Vocational case management – ABVE, COHN, CRC, CRRN, CVE, CDMS, or CCM credentials
- ☐ **84** Professional counselor (licensed) and social worker (licensed) Ohio counselor, social worker, and MFT board license
- ☐ **86** Employment specialist – (individual) ABVE, CRC, CCM, CESP, CIPS, GCDF, ACC, PCC, MCC, CDMS, or CARF individual accreditation for employment and community services in job development or employment supports; OR educational courses – addendum sent upon receipt
- ☐ **88** Professional clinical counselor (licensed) and independent social worker (licensed) Ohio counselor, social worker, and MFT board license
- ☐ **89** Speech – Language pathologist – state speech and hearing professional's board
- ☐ **90** Ergonomist – CPE, CHFP, AEP, AHFP, CEA, CSP with ergonomics specialist designation, CIE, CIH, ATP, or RET

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

- ☐ **01** Air ambulance – Private: license from Ohio Medical Transportation Board; public/government: Medicare participation
- ☐ **02** Ambulance/Ambulette service – Private: license from Ohio Medical Transportation Board; public/government: Medicare participation
- ☐ **03** Ambulatory surgical center: Ohio Department of Health license and Medicare participation
- ☐ **08** Adult day care facility – Ohio Department of Aging Passport adult day care provider agreement
- ☐ **10** Clinic – Drug/alcohol (free standing) – Ohio Mental Health and Addiction Services certification
- ☐ **11** Pain clinic (free standing) – CARF accreditation; hospital based, CARF or Joint Commission accreditation
- ☐ **13** ASC Arthroplasty Center – Ohio Department of Health license and Medicare participation AND complete application addendum that will be sent upon receipt
- ☐ **16** Dialysis center/ESRD clinic (free standing) – Ohio Department of Health certification and Medicare participation (directly or through an accrediting organization approved by CMS)
- ☐ **17** Durable medical equipment supplier – Ohio board of pharmacy home medical equipment certificate of registration and Medicare participation
- ☐ **18** Sleep lab – Certification from American Academy of Sleep Medicine and Medicare participation (directly or through an accrediting organization approved by CMS)
- ☐ **19** Independent Diagnostic Testing Facility – Medicare participation
- ☐ **30** Home health agency – Medicare participation (directly or through an accrediting organization approved by CMS)
- ☐ **32** (HHA) Hospice – Ohio Department of Health license and Medicare/Medicaid participation
- ☐ **34** Hospital – General/acute – Medicare participation (directly or through an accrediting organization approved by CMS), *Note: Hospital provider based urgent care centers/clinics should enroll under appropriate hospital provider type
- ☐ **35** Hospital – per diem services (detox inpatient stay) - Joint Commission accreditation, AOA HFAP accreditation Medicare participation
- ☐ **36** Hospital – Psychiatric – Joint Commission accreditation, AOA HFAP accreditation, or Medicare participation
- ☐ **37** Hospital – Rehabilitation/long-term acute hospital – CARF or Medicare participation (directly or through an accrediting organization approved by CMS)
- ☐ **45** Laboratory – CMS CLIA certificate
- ☐ **53** Nursing home – Ohio Department of Health license or Medicare participation
- ☐ **56** Residential care/Assisted living – Ohio Department of Health license or Medicare participation
- ☐ **75** Radiology services (free standing) – Ohio Department of Health license or registration, Joint Commission accreditation or Medicare or Medicaid participation
- ☐ **82** Rehabilitation – Traumatic brain injury facility – CARF accreditation for brain injury services
- ☐ **87** Rehabilitation – Vocational case management intern – application addendum required and will be sent upon receipt
- ☐ **96** Urgent care center (free standing) – Medicare participation, *Note: Hospital (provider) based urgent care centers/clinics will be enrolled as type 34 and must meet those credentials

Section 2 – General information

MEDCO-13

1 Current BWC provider number *(If known)* | Tax identification number *(Please attach a copy of the IRS W-9. This number will be used for IRS purposes).*

2 Business legal name and Doing-business-as name *(must appear as recognized by the IRS and on submitted W-9)* | W-9 shows 1099 address? ☐ Yes ☐ No *If no, attach address.*

3 Business NPI number *(Attach NPI enumerator verification).* | Taxonomy code(s) for business

4 Business types: **Check one — Must match W-9 submitted** ☐ Individual/Sole proprietor ☐ Single member LLC ☐ Limited liability company ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/Estate ☐ Other _____

5 Business owner name(s); define 100 percent of ownership, designate interest amount per owner

6 ☐ Check here if no employees | Workers' compensation employer policy number ***(Required** if you have employees) Attach certificate of coverage.*

7 Individual provider name *(First name, middle initial, last name)* | Social Security number *(required for individuals)* | ☐ Male ☐ Female

8 Individual NPI number *(Attach NPI enumerator verification.)* | Taxonomy code(s) *(Attach NPI enumerator verification.)*

9 Practice location street address *(Indicate the address where you render services, including suite, floor, etc. Do not use P.O. Box.)* ***Add all secondary addresses on separate page.***

10 City | State | Nine-digit ZIP code

11 Telephone ( ) | Fax ( )

12 Email for office/provider (**required**)

13 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.)*

14 City | State | Nine-digit ZIP code

15 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.)*

16 City | State | Nine-digit ZIP code

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

18 List all Medicare number(s) as indicated under provider type requirement in Section 1. If hospital provider type, designate all numbers to matching types (types: rehab hospital Medicare number, psych hospital Medicare number, acute/general hospital Medicare number, long-term acute care hospital Medicare number).

19 Medicaid number *(as indicated by specific provider type requirements in Section 1 - attach participation verification)*

Section 3 – Individual provider information – Amer. Board of Medical Specialties (ABMS), Amer. Dental Assn. (ADA), Amer. Osteopathic Assn. *(Submit copy of certificate)*

1 List board specialty ☐ ABMS ☐ ADA ☐ AOA ☐ Chiropractic Diplomate | Date certified

2 List board specialty ☐ ABMS ☐ ADA ☐ AOA ☐ Chiropractic Diplomate | Date certified

Foreign languages spoken | Date of birth ***(required)***

Provider home address

City | State | Nine-digit ZIP code

Education/training

Institution type	Year graduated	Degree/Certification	Certificate/License no.	Expiration date

The provider types below require malpractice and liability insurance coverage

05 Non-physician acupuncturist	38 DM	70 DPM
07 Anesthesiologist assistant	52 Certified registered nurse anesthetist	72 Psychologist
09 DC	59 OD	84 Professional counselor/Social worker
15 DDS	66 DO	88 Professional clinical counselor/Independent social worker
33 Advance practice nurse	67 MD	

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. In the previous five years, have you 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 disciplinary restrictions that affect your ability to treat patients or that compromise patient care? ☐ 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 Ohio 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

Do you have a history of:

9. A conviction or plea of guilty to a criminal offense, other than as specified in Question 10 below? ☐ Yes ☐ No
10. 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 5 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
11. 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 5 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
12. An entry of judgment against the provider, or any person having a 5 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
13. Do you refer patients for testing or treatment to any facility with which you or an immediate family member have a 5 percent or greater ownership or investment interest, or a compensation arrangement? ☐ Yes ☐ No
14. In my practice: ☐ I accept new patients or ☐ I do not accept new patients or ☐ Patients should contact my office to see if we are accepting new patients.

Explanation: _____

Application contact person *(person completing form)*	Title
Telephone number ( )	Fax number ( )
Email 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) 4123-6-02.5 and OAC 4123-6-17 for failure to adhere to conditions below.

Provider agrees to abide by the Ohio Revised Code (ORC) and rules promulgated thereunder by BWC and the Ohio Industrial Commission. 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*, which is incorporated by reference into this application/agreement, and all other terms of this application/agreement.

Provider agrees to notify BWC within 30 days of any change in the provider's business address/location, business name, NPI number, Social Security number (if applicable), employer ID number, tax identification number and/or ownership, or any change in the provider's status regarding any of the credentialing criteria of paragraphs (B) or (C) of OAC 4123-6-02.2.

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 and to adhere to MCO and BWC procedures and requirements concerning provider compliance, outcome measurement data, peer review, quality assurance, utilization review, bill submission, dispute resolution, and reporting of injuries and occupational diseases of employees. Provider agrees to acknowledge and treat injured workers in accordance with BWC recognized treatment guidelines and the vocational rehabilitation hierarchy, adhere to BWC's confidentiality and sensitive data requirements, and to use information obtained from BWC by means of electronic account access for the sole purpose of facilitating treatment and no other purpose, including but not limited to engaging in advertising or solicitation directed to injured workers.

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 professional malpractice and liability insurance (commercial liability insurance if applicable).

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 supplies that the provider has delivered, rendered or directly supervised and that are medically necessary, cost-effective, and reasonably related to the claimed or allowed condition related to the industrial injury or occupational disease. 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 4123-6-45.1. Provider further agrees to make such records available for review by BWC, self-insuring employer, appropriate certified MCO and/or QHP within 30 days or such time as agreed to by the parties, in accordance with OAC 4123-6-45.

Provider agrees to keep injured worker patient records (including but not limited to those records set forth under OAC 4123-6-45.1) confidential, and to maintain the confidentiality of injured worker patient records in accordance with all applicable state and federal statutes and rules, and prevent such information from further disclosure or use by unauthorized persons.

If the provider is of a type listed in Section 1 as requiring malpractice and liability insurance coverage, provider attests that it presently has malpractice and liability insurance, and that it shall maintain such coverage at all times during the course of this contract. Provider agrees to provide proof of such coverage to BWC upon request.

Pursuant to Ohio Revised Code (ORC) 9.76(B) Provider warrants that Provider is not boycotting any jurisdiction with whom the State of Ohio can enjoy open trade, including Israel, and will not do so during the contract period.

Conflict of interest and ethics law compliance certification

Provider affirms he or she 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 that are required to be performed under this contract. In addition, provider affirms 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 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.

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. 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)***	Date

Please print or type name