

## 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. Minimum credentials for providers are established 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 must 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 15249  
Columbus, OH 43215-0249  
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 NPI enumerator), if applicable;
- Proof of Telemedicine certificate from Medical board or Accupuncture certificate from Chiropractic Board, 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](http://ohiobwc.com).

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

| If you check one of the following, complete sections 2, and 5 and attach the required documents. |           |   |                          |           |   |
|--|-----------|---|--------------------------|-----------|---|
| <input type="checkbox"/>   | <b>01</b> | Air ambulance – private: license from Ohio Medical Transportation Board; public/government: Medicare participation  | <input type="checkbox"/> | <b>35</b> | Hospital – drug/alcohol – Joint Commission accreditation, AOA HFAP accreditation or Medicare participation and Ohio Dept. of Alcohol and Drug Addiction Services certification        |
| <input type="checkbox"/>   | <b>02</b> | Ambulance/Ambulette Service – private: license from Ohio Medical Transportation Board; public/government: Medicare participation  | <input type="checkbox"/> | <b>36</b> | Hospital – psychiatric – Joint Commission accreditation, AOA HFAP accreditation or Medicare participation   |
| <input type="checkbox"/>   | <b>03</b> | Ambulatory surgical center: Ohio Department of Health license and Medicare participation  | <input type="checkbox"/> | <b>37</b> | Hospital – rehabilitation/long-term acute hospital – CARF, Joint Commission and AOA HFAP accreditation or Medicare participation  |
| <input type="checkbox"/>   | <b>10</b> | Clinic – drug/alcohol (free standing) – state department of alcohol and drug addiction services certification   | <input type="checkbox"/> | <b>45</b> | Laboratory – CMS CLIA certification   |
| <input type="checkbox"/>   | <b>11</b> | Pain clinic – free standing – CARF accreditation; hospital based, CARF or Joint Commission accreditation  | <input type="checkbox"/> | <b>53</b> | Nursing home – State Health department license or Medicare participation  |
| <input type="checkbox"/>   | <b>16</b> | Dialysis center/ESRD clinic (free standing) – state health department certification and Medicare participation  | <input type="checkbox"/> | <b>56</b> | Residential care/Assisted living – State Health department license or Medicare participation  |
| <input type="checkbox"/>   | <b>17</b> | Durable medical equipment supplier – State vendors license and Ohio Respiratory Care Board Home Medical Equipment license or certificate of registration and Medicare participation, or Joint Commission or CHAP accreditation  | <input type="checkbox"/> | <b>75</b> | 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"/>   | <b>30</b> | Home health agency – Medicare participation (directly or through agency with “deeming” CMS authority), Joint Commission or CHAP accreditation   | <input type="checkbox"/> | <b>82</b> | Rehabilitation – traumatic brain injury facility – CARF accreditation   |
| <input type="checkbox"/>   | <b>32</b> | (HHA) Hospice – State health department license and Medicare/Medicaid participation   | <input type="checkbox"/> | <b>87</b> | Rehabilitation – vocational case management intern – application addendum required and will be sent upon receipt  |
| <input type="checkbox"/>   | <b>34</b> | Hospital – general/acute – Joint Commission accreditation, AOA HFAP accreditation or Medicare participation, * Note: Hospital provider based urgent care centers/clinics should enroll under appropriate hospital provider type | <input type="checkbox"/> | <b>96</b> | 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**

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|    |  |  |  |   |
|----|--|--|--|---|
| 1  | Current BWC provider number <i>(If known)</i>  | Business NPI number (attach NPI enumerator verification)                                     |  |   |
| 2  | Business name or dba name <i>(If applicable)</i>   | Taxonomy code(s) (attach NPI enumerator 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<br><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<br><input type="checkbox"/> Female |   |
| 8  | Individual NPI number (attach NPI enumerator verification)   | Taxonomy code(s) (attach NPI enumerator 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<br>(   )   | Fax<br>(   )   | 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 hospital provider type, designate all numbers to matching types (types are: rehab hospital Medicare number, psych hospital Medicare number, acute/general hospital Medicare number, long-term acute care hospital 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<br><input type="checkbox"/> AOA<br><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> |                       |  |                                       |                        |
| <b>Institution type</b>   | <b>Year graduated</b> | <b>Degree/Certification</b>  | <b>Certificate/License no.</b>        | <b>Expiration date</b> |
|   |                       |  |                                       |                        |
| 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) | 72 Psychologist  |
| 09 Physician (DC)              | 59 Optometrist (OD)                              | 84 Professional counselor/social worker                      |
| 15 Dentist (DDS)               | 66 Physician (DO)                                | 88 Professional clinical counselor/independent social worker |
| 33 Advance practice nurse      | 67 Physician (MD)                                |  |
| 38 Mechanotherapist (DM)       | 70 Physician (DPM)                               |  |

**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 disciplinary restrictions, (including but not limited to disciplinary restrictions related to chemical dependency or substance abuse) 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 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 involving moral turpitude; 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 5 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<br>( )                 | Fax number<br>( ) | 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) 4123-6-02.5 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 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*, 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, National Provider Identifier (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 managed care organization (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.

## Section 5 – Provider application/agreement (cont.)

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 adequate, current 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 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 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.

### Conflict of interest and ethics law compliance certification

Provider affirms 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 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