Dear New Provider:

Welcome! Thank you for your interest in providing medical services for injured and ill workers served by the U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP).

OWCP administers three major compensation programs that provide wage replacement, medical treatment, pharmaceutical and vocational rehabilitation benefits to certain workers who experience work-related injuries or occupational disease. These programs are:

- Division of Federal Employees' Compensation (DFEC) - Federal Employees Compensation Act (FECA)
- Division of Energy Employees Occupational Illness Compensation (DEEOIC) - Energy Employees Occupational Illness Compensation (EEOIC)
- Division of Coal Mine Workers' Compensation (DCMWC) - Coal Mine Workers' Compensation (CMWC)

All three programs reimburse medical and non-medical providers for services rendered for the care and treatment of a claimant's compensable conditions. Providers can enroll in any one or more of the three OWCP compensation programs.

To enroll as a provider:

- https://owcpmed.dol.gov/portal/provider/get-started

Detailed provider enrollment instructions can be found using the online tutorials below:

- Facility Enrollment
  https://owcpmed.dol.gov/portal/tutorials/WCMBP_Facility_Provider_Enrollment.pdf
- Group Enrollment
  https://owcpmed.dol.gov/portal/tutorials/WCMBP_Group_Provider_Enrollment.pdf
- Individual Enrollment
  https://owcpmed.dol.gov/portal/tutorials/WCMBP_Individual_Provider_Enrollment.pdf

For questions about completing the enrollment form, please contact OWCP's medical bill processing contractor Enrollment Call Center at 844-493-1966, Monday through Friday from 8:00 a.m. to 8:00 p.m., Eastern Time.

Upload completed enrollment form and required documents to the Workers Compensation Medical Bill Processing Portal (WCMBP) https://owcpmed.dol.gov /portal for enrollment processing. To mail or fax your enrollment form and required documents use the following:

Mail:
Provider Enrollment
P. O. Box 8312
London, KY 40742-8312

Fax:
888-444-5335

Providers that operate from multiple offices are required to complete a separate enrollment form for each office location.

Providers who enroll under the group practice (Addendum 1 of the enrollment form) are not required to enroll separately. Providers are responsible for monitoring the business licensure for the entity enrolled, as well as the professional licensure for servicing providers within the practice.

Payments made for your services will be made by electronic fund transfer (EFT) as required by the Debt Collection Improvement Act of 1996, except for exempt providers. For EFT, visit Bureau of the Fiscal Service to complete the ACH Vendor/Miscellanous Payment Enrollment Form.

A remittance notice listing all bills paid on each transaction will be sent to your mailing address and available through the OWCP Medical Provider Portal.

OWCP provides claimants an online listing of enrolled providers by program, which is searchable by specialty, name, city, state, and zip code. Claimants are advised that a provider listing is not an endorsement, referral, or an agreement to reimburse for medical services rendered by the Department of Labor or OWCP. Also, the listing does not guarantee claimants that a medical provider will agree to provide medical services to a particular claimant.

OWCP looks forward to working with you!

NOTICE: Continued participation as a medical provider under the DOL programs above can be contingent on your maintaining good standing as a medical provider under other federal health benefit programs such as Medicare. Exclusion as a medical provider in those circumstances operates as an automatic exclusion under the FECA and EEOICPA. Programs administered by OWCP. (See 20 C.F.R. §§ 10.815, 30.715, and 702.431). You may also be subject to the federal government's suspension and debarment provisions. (See 48 C.F.R. Subpart 9.4 and 2 C.F.R. Part 180).

Provider Enrollment Form Print Reset

U.S. Department of Labor

Office of Workers' Compensation Programs

OMB Number 1240-0021
Expires: 12/31/2026

1. Are you applying for a new enrollment or updating your record?

☐ New Enrollment ☐ Re-Enrollment ☐ Re-Validation ☐ Update (For Update, ONLY complete sections you wish to change, then Confirm and Sign on page 8.)

1a. If Update, Re-Enrollment or Re-Validation,

Enter Provider ID or Federal Employer Identification Number (FEIN)

PART A: BASIC INFORMATION (All fields in this section are required; if "other" is selected, explanation is required.)

2. Enrollment Type (Refer to Instructions for additional information)

☐ Individual

☐ Group Practice (Please see Page 9 - Addendum 1, for completion of group practice enrollment for each professional)

☐ Facility/Agency/Organization/Institution

3. Provider Type Select

(For multi-specialty group provider, select primary provider type. Refer to Appendix 1 & 3 for more information.)

If selecting "Other Provider" (96) or Non-Medical Vendor (53), please complete 3a.:

3a. Please explain

4. Program (Check the Program(s) in which you want to enroll as a provider.)

☐ DFEC ☐ DCMWC ☐ DEEOIC ☐ DLHWC

5. Individual Information (If enrolling using SSN) Reset

5a. Last Name

5b. First Name

5c. Middle Name

5d. SSN

6. Organization Information (If enrolling using FEIN)

6a. Organization Name (Legal Business Name)

6b. Organization Business Name (Doing Business As)

6c. FEIN

7. National Provider Identifier (NPI) (Refer to Appendix 3)

8. Entity Type Select

8a. If Other, please explain

9. Email Address

10. ☐ I do not wish to be included in an online searchable list of OWCP providers.

10a. Reason

PART B: LOCATION (All fields are required. If not applicable specify N/A.)

11. Location Contact Information (Providers offering services at different location(s) are required to enroll separately for each location. Servicing providers under a group practice are not required to enroll separately.)

11a. Business Name

11b. Contact Last Name | 11c. Contact First Name

11d. Phone Number | 11e. Fax Number

11f. Email Address

12. Physical Address

12a. Address Line 1

Address Line 2

Address Line 3

12b. City/Town | 12c.State/Province Select | 12d. Zip Code

12e. County | 12f. Country

13. Mailing Address ☐ Same as Physical Address

13a. Address Line 1

Address Line 2

Address Line 3

13b. City/Town | 13c. State/Province Select | 13d. Zip Code

13e. County | 13f. Country

PART C: TAXONOMY (Required if applicable.)

14. Taxonomy Code(s) a. b. c. d. e.

PART D: OWNERSHIP DETAILS (Optional. Refer to Instructions for additional information.)

15. Organization Owner (If enrolling using FEIN) Reset

15a. Organization Name | 15b. FEIN

16. Individual Owner

16a. Last Name | 16b. First Name | 16c. SSN

17. Address (If enrolling using SSN)

17a. Address Line 1

Address Line 2

Address Line 3

17b. City/Town | 17c. State/Province Select | 17d. Zip Code

17e. County | 17f. Country

Additional Ownership Information (Section 18 to 20 are for additional ownership information. Use additional sheets as required.)

18. Organization Owner Reset

18a. Organization Name | 18b. FEIN

19. Individual Owner

19a. Last Name | 19b. First Name | 19c. SSN

20. Address

20a. Address Line 1

Address Line 2

Address Line 3

20b. City/Town | 20c. State/Province Select | 20d. Zip Code

20e. County | 20f. Country

PART E: LICENSE AND CERTIFICATION (Required for Individual and Facility/Agency/Organization enrollment types. Please refer to Instructions on page 14 for additional information.)
Group practice providers may skip Sections E and F, and continue at Section G through Addendum 1.

21a. License/Certification Category Select	21b. Name
21c. License/Certification Type	21d. License/Certification Number
21e. Initial Issue Date	21f. Expiration Date
21g. Issued State Select	21h. Issuer Agency
21i. Web Link	

21j. License/Certification not required by State. (Select if License/Certification is not required by State.)

21k. Please explain

Additional License/Certification (Use additional sheet(s) as required)

22a. License/Certification Category Select	22b. Name
22c. License/Certification Type	22d. License/Certification Number
22e. Initial Issue Date	22f. Expiration Date
22g. Issued State Select	22h. Issuer Agency
22i. Web Link	

PART F: IDENTIFIERS

23. Provider Identifier Information (Medicare number is required for hospitals (Provider type: 01, 02, 03).)

23a. Identifier Type	Select	23b. Identifier Value	
23c. Start Date		23d. End Date	

24. Additional Provider identifier information (Use additional sheet(s) as required)

24a. Identifier Type	Select	24b. Identifier Value	
24c. Start Date		24d. End Date	

PART G: EDI SUBMISSION METHOD

25. Mode of Submission. Check all applicable (See Instructions on page 15 for details regarding modes of submission).

- ☐ Billing Agent/Clearinghouse
- ☐ Web Interactive
- ☐ FTP Secured Batch
- ☐ Web Batch
- ☐ None

PART H: EDI SUBMITTER DETAILS (Required if Billing Agent/Clearinghouse selected in Part G).

26. Billing Agent/Clearinghouse/Submitter Information (See Instructions for further details.)

26a. Billing Agent/Clearinghouse OWCP ID			
26b. Start Date		26c. End Date	

PART I: EDI CONTACT DETAILS (Required if submitting EDI).

27. EDI Contact Information

27a. Contact Title

27b. Last Name | 27c. First Name

27d. Phone Number | 27e. Fax Number

27f. Email Address

28. Address

28a. Address Line 1

Address Line 2

Address Line 3

28b. City/Town | 28c. State/Province Select | 28d. Zip Code

28e. County | 28f. Country

29. Additional EDI Contact Information

29a. Contact Title

29b. Last Name | 29c. First Name

29d. Phone Number | 29e. Fax Number

29f. Email Address

30. Address

30a. Address Line 1

Address Line 2

Address Line 3

30b. City/Town | 30c. State/Province Select | 30d. Zip Code

30e. County | 30f. Country

Privacy Act Statement

Collection of this information by OWCP is necessary for its administration of the Federal Employees' Compensation Act, the Black Lung Benefits Act, the Longshore and Harbor Workers' Compensation Act and the Energy Employees Occupational Illness Compensation Program Act, and is authorized under 20 CFR 10.800, 20 CFR 30.700, 20 CFR 702.145, 20 CFR 725.714 and 33 USC 918(b). The information provided will be used to ensure accurate payment of medical and vocational rehabilitation provider bills and is protected by the Privacy Act of 1974, as amended (5 USC 552a) in accordance with the following systems of records: DOL/GOVT-1, DOL/OWCP-4 DOL/OWCP-9 and DOL/OWCP-11, published in the Federal Register, Vol. 81, page 25766, April 29, 2016, or as updated and republished. Completion and submission of this form is voluntary; however, failure to provide the information (including SSN or FEIN) will result in substantially delayed payment of bills. This information will be furnished to OWCP and its data processing contractors and may also be disclosed to other federal and state agencies in connection with the administration of other programs, to the Department of Justice for litigation purposes, and to medical and other provider review boards. Additional disclosures may be made through the routine uses for information contained in the referenced systems of records.

Public Burden Statement

Under the Paperwork Reduction Act., persons are not required to respond to a collection of information unless such collection displays a valid OMB control number. We estimate that it will take an average of 25 minutes to complete this information collection, including time for reviewing the instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this collection including suggestions for reducing this burden, send them to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. DO NOT SEND THE COMPLETED FORM TO THE ABOVE ADDRESS.

Notice

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or the claims examiner to ask about this assistance.

Disclosure Statement

Within ten years of the date of this statement have you or any individual listed on this application had an action related to fraud or abuse in a government program taken against him or her resulting in (1) a felony or misdemeanor conviction; (2) a liability finding in civil proceedings; or (3) a settlement entered in lieu of conviction? ☐ Yes ☐ No

If Yes, provide details including type of action, Agency undertaking adverse action and date of action.

Required for DFEC providers

For Provider Type "Medical Supplies/Durable Medical Equipment (DME) / Prosthetics / Orthotics" (75) only:

Are you an accredited DMEPOS supplier enrolled with Medicare? ☐ Yes ☐ No

If Yes, provide the phone number that you used in your Medicare DMEPOS enrollment.

Confirm and Sign

I, the undersigned, certify to the following: I have read the contents of this application, and the information contained herein is true, correct, and complete.

I certify that I and my agents have currently in effect all necessary licenses, certifications, approvals, insurance, etc. required to properly provide the services and/or supplies for the OWCP in the state, county, locality, or jurisdiction where the services and/or supplies are provided. I will provide proof of such licenses, certifications, approvals, insurance, etc. upon the OWCP's request. I understand that any revocation, withdrawal, or non-renewal of necessary license, certification, approval, insurance, etc. required for me to properly provide services, shall be grounds for termination of enrollment/registration by the OWCP.

I authorize the OWCP to verify the information contained herein. I agree to notify the OWCP of any change in ownership, practice location and/or Final Adverse Action involving fraud or abuse within 30 days of the reportable event. In addition, I agree to notify the OWCP of any other changes to the information in this form within 90 days of the effective date of change.

I also certify that I am not currently sanctioned, suspended, debarred or excluded by any Federal or State Health Care Program, (e.g., Medicare, Medicaid, or any other Federal program), or otherwise prohibited from providing services to Medicare, Medicaid, or other Federal program beneficiaries nor are any owners, officers, or managing employees of the practice listed in this application.

I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to the Department of Labor, Office of Workers' Compensation Program (OWCP), or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of OWCP billing privileges, civil damages, and/or imprisonment.

I agree to abide by the OWCP regulations and program instructions that apply to me or to the organization listed in Section 3A of this enrollment form. I understand that payment of a claim by OWCP is conditioned upon the claim and the underlying transaction complying with state and federal laws (including, but not limited to, the Federal anti-kickback statute) and OWCP regulations, and program instructions.

☐ I have completed an ACH Vendor Payment/Electronic Fund Transfer (EFT) form. (Please attach ACH form).

Print Name and Title

Signature Date

Print, sign and mail or fax form to the following address:

Provider Enrollment
Department of Labor - OWCP
P. O. Box 8312
London, KY 40742-8312
Fax: 888-444-5335

Addendum 1: Servicing Providers Information for Group Practice Enrollment
(All fields are required for providers enrolled as Group Practice. Refer to Instructions and Appendices 1 and 3 for additional information.)
Fill in this addendum to add, update or remove servicing providers for Group Practice. Use additional sheet(s) as required.

1.
☐ Add
☐ Update
☐ Remove

2. Individual Information (If enrolling using SSN)

Reset

2a. Last Name
2b. First Name
2c. Middle Name
2d. SSN

3.Organization Information (If enrolling using FEIN)

3a. Organization Name
3b. Organization Business Name
3c. FEIN

4. Provider Type Select
5. NPI
6. Taxonomy a. b. c. d. e.

7. License/Certification Information

License/ Certification Category	License/Certification Type	License/ Certification Number	Issued State	Initial Issue Date	Expiration Date
Select			Others		
Select			Select		

Additional Addendum Information

1.
☐ Add
☐ Update
☐ Remove

2. Individual Information (Applicable if enrolling using SSN)

Reset

2a. Last Name
2b. First Name
2c. Middle Name
2d. SSN

3. Organization Information (Applicable if enrolling using FEIN)

3a. Organization Name
3b. Organization Business Name
3c. FEIN

4. Provider Type Select
5. NPI
6. Taxonomy a. b. c. d. e.

7. License/Certification Information

License/ Certification Category	License/Certification Type	License/ Certification Number	Issued State	Initial Issue Date	Expiration Date
Select			Select		
Select			Select		

Addendum 2: Taxonomy Information

Type or print additional Taxonomy information as applicable.

Use additional sheet(s) as required.

Taxonomy

Addendum 3: License and Certification

Type or print additional license and certification information as applicable.

Use additional sheet(s) as required

1. License/Certification Category Select	2. Name
3. License/Certification Type	4. License/Certification Number
5. Initial Issue Date	6. Expiration Date
7. Issued State Select	8. Issuer Agency
9. Web Link	

1. License/Certification Category Select	2. Name
3. License/Certification Type	4. License/Certification Number
5. Initial Issue Date	6. Expiration Date
7. Issued State Others	8. Issuer Agency
9. Web Link	

1. License/Certification Category Select	2. Name
3. License/Certification Type	4. License/Certification Number
5. Initial Issue Date	6. Expiration Date
7. Issued State Select	8. Issuer Agency
9. Web Link	

Addendum 4: Billing Agent/Clearinghouse Provider ID

Type or print additional Billing Agent/Clearinghouse Provider IDs as applicable.

Use additional sheet(s) as required.

Billing Agent/Clearinghouse ID	Start Date	End Date

Instructions

A brief description and additional information for parts of the form is listed below. Be sure to sign and date the form when you submit it.

Part A: Basic Information		
1.	New Enrollment - New Providers select when not previously enrolled with OWCP Re-Enrollment - Previously enrolled Provider was excluded, now has become eligible to enroll with OWCP Re-Validate - Current Provider who is enrolled with OWCP but has expired information on the provider enrollment record. Update - Current Provider who is enrolled with OWCP and needs to update existing information on the provider enrollment record	Required
2.	Select Enrollment Type: Individual • Any provider who is eligible to receive a Type I National Provider Identifier (NPI) through the National Plan and Provider Enumeration System (NPPES). Providers eligible to receive an NPI are those who deliver medical or health services, as defined under Section 1861(s) of the Social Security Act, 42 U.S.C. 1395x(s). • Individuals providing only non-medical services, attendant care, or personal care services, who do not need an NPI. Group Practice • One or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment) and have formed a partnership or corporation or are employees of a person, partnership or corporation, or other entity owning or operating the health care facilities at which they practice. These entities have a Type II National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES). Facility/Agency/Organization/Institution • An Inpatient or Outpatient Hospital, a Skilled Nursing Facility, an Intermediate Care Facility, a Clinic (RHC, FQHC, Hospital Based Clinic, Urgent Care), a Psychiatric Facility, a Mental Institution, a Durable Medical Equipment Supplier, a Free Standing Ambulatory Surgical Center, a Long Term Care Facility, an Independent Clinical Laboratory, a Free Standing Radiology, a Dialysis Center, a Pharmacy, a Partnership, a Corporation, or any other entity that furnishes or arranges for the furnishing of services for which payment is billed under the OWCP programs. It does not include individual practitioners or groups of practitioners. In addition, you must also be eligible to receive and currently possess, a Type II National Provider Identifier, available through the National Plan and Provider Enumeration System (NPPES). • Any entity other than individual who does not deliver medical care or health services and is thus ineligible for a National Provider Identifier (NPI) available through the National Plan and Provider Enumeration System (NPPES). This provider type can include Fiscal • Intermediaries, Non-Emergency Transportation, etc.	Required Refer to Appendix 2 for more information
10.	Select this option if you do not wish to be included in the OWCP online searchable program. However, selecting this option will not exclude your information in a FOIA (Freedom Of Information Act) request.	

Part C: Taxonomy		
14.	Use Addendum 1 for taxonomy for servicing providers Use Addendum 2 for additional taxonomy codes. Use additional sheet(s) as required.	Refer to Appendix 3 for provider type taxonomy requirements

Part D: Ownership Details (OPTIONAL)	Part D is optional. For DFEC and DEEOIC providers, list any business with more than a 5% interest in or where involvement is at an officer, director or agent of the company

Part E: License and Certification		
• Please complete and attach copies of all license/certification required by your State to perform the service under your Provider Type. • If a license or certification is not required by the State, attach letter/ evidence from the State authority. • OWCP will verify all your license/certification with your State's license issuer agency before your enrollment can be approved. • After your enrollment is approved, you are responsible to keep your license/certification information up to date. • Expired license/certification will cause the termination of the provider status. • If you have a renewed license/certification under a different number, please make sure to enter it using the exact same License/Certification Type.		Required for Individual and Facility/Agency/ Organizational enrollment types.
21.	• Use Addendum 1 for license and certification information of servicing providers for group practice enrollment. • Refer to Addendum 3 to add additional license and certification information. Use additional sheet(s), as required.	Refer to Appendix 3 for requirements
21a.	Type or print license or certification category from following options: • License • certification	If submitting a copy of your licenses and/or certifications skip 21b through 21i
21k.	Type or print Explanation and attach letter/evidence from State authority	Required if 21j. is selected

Part G: EDI Submission Method		
25.	Select mode of Submission. Select all applicable options: Billing Agent/Clearinghouse — For providers who use a 3rd party to bill. Web Interactive — For entering (keying) bills directly in the System. FTP Secured Batch: — For submitting files via an SFTP site. Web Batch — For upload/download of files in the system. None — For submissions through paper form ONLY. • "Web Batch" method is often used by providers who submit their own HIPAA batch transactions. It allows a maximum file size of 50 MB. • Your EDI submission method is "FTP Secured Batch" if you submit and retrieve batches at a secure web folder assigned to you by OWCP. This method was designed with clearinghouses and billing agents in mind. It allows a maximum file size of 100 MB. • Don't select “None” if other submission method is selected. You can always submit paper form in addition to EDI Submission.	

Part H: EDI Submitter Details		
26.	Billing Agent/Clearinghouse information • Your Billing Agent/Clearinghouse must be enrolled with OWCP first. • Please obtain the Billing Agent/Clearinghouse’s OWCP ID to complete this section. • If they are not yet enrolled, you can still complete your enrollment by temporarily choosing not to use Billing Agent/Clearinghouse. • You can add them later after they are enrolled with OWCP. Refer to Addendum 4 for additional information. Use additional sheet(s) as required.	Required if Billing Agent/Clearinghouse selected in Part G

Addendum 1: Servicing Providers Information		Required for enrollment type Group Practice
1.	Select one option to add, update or remove a servicing provider: • For New Enrollment, only Add action can be selected. • Type or print all the information for New and Update Action. • Type or print SSN or FEIN for Remove Action. • Servicing providers can be enrolled using SSN (individual) or FEIN (organization).	Required

Appendix 1: Provider/Hospital Type Codes

01	General Hospital
02	Special Hospital/ Rehabilitation Facility
03	Psychiatric Hospital
05	Community Mental Health Center
20	Pharmacy
25	Physician (MD) & Physician (DO)
27	Podiatrist
28	Chiropractor
29	Physician Assistant
30	Advanced Registered Nurse Practitioner (ARNP)
31	Certified Registered Nurse Anesthetist (CRNA)
32	Psychologist
33	Contract Medical Consultant
34	Licensed Midwife
35	Dentist
36	Registered Nurse (RN)
37	Licensed Practical Nurse (LPN)
38	Nursing Attendant
40	Ambulance
41	Contract Nurse
42	Air/Water Ambulance Company
43	Taxi
44	Public Transportation & Private Transportation
46	Hospice
47	FOH-DMA Providers
50	Independent Laboratory
51	Portable X-Ray Company
52	Alternative Medicine (e.g., Massage Therapist/Acupuncturist)
53	Non-Medical Vendor
55	Vocational Rehabilitation (Training, Tuition and Schools)
56	Vocational Rehabilitation Counselor
57	Rehabilitation Maintenance
58	Assisted Re-employment
59	Relocation Expenses
60	Audiologist/Speech Pathologist
61	Second Opinion Contractor
62	Optometrist
63	Optician
65	Home Health Agency
66	Rural Health Clinic
67	DMA Consult Contractor
68	Federally Qualified Health Center
69	Birthing Center
70	Health Maintenance Organization or Preferred Health Plan
71	Physical Therapist
72	Occupational Therapist
73	Pulmonary Rehabilitation
74	Outpatient Renal Dialysis Facility
75	Medical Supplies/Durable Medical Equipment (DME) /Prosthetics/Orthotics
76	Case Management Agency
77	Social Worker
78	Blood Bank
80	Pay-to-Intermediary
88	Ambulatory Surgery Center
89	Federal Facility (VA Hospital)
90	Skilled Nursing Facility (SNF)-Medicare Certified & Non-Medicare Certified
92	Intermediate Care Facility (ICF)
93	Rural Hospital Swing Bed
94	Boarding House
95	Insurance Company (Third party Carriers)
96	Other Provider
97	Billing Agent
98	Lien Holder

Appendix 2: Enrollment Type/Provider Type

Applicable provider types for each enrollment type are listed:

Enrollment Type	Provider Type
Individual	25, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 40, 41, 42, 43, 44, 47, 50, 51, 52, 53, 55, 56, 57, 58, 59, 60, 61, 62, 63, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 80, 88, 95, 96, 98
Group Practice	25, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 43, 52, 60, 62, 63, 65, 66, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 96
Facility/Agency/Organization/Institution	01, 02, 03, 05, 20, 40, 42, 43, 44, 46, 50, 51, 53, 55, 57, 58, 59, 65, 66, 68, 69, 70, 73, 74, 75, 76, 78, 80, 88, 89, 90, 92, 93, 94, 95, 96, 98

Appendix 3: Provider Type Matrix

Provider Type	NPI required?	Taxonomy required?	License/Certification required?	Applicable Program(s)	Self-Enrollment allowed? **
01	✔	✔	✔	All	✔
02	✔	✔	✔	All	✔
03	✔	✔	✔	All	✔
05	✔	✔	✔	All	✔
20	✔	✔	✔	All	✔
25	✔	✔	✔	All	✔
27	✔	✔	✔	All	✔
28	✔	✔	✔	All	✔
29	✔	✔	✔	All	✔
30	✔	✔	✔	All	✔
31	✔	✔	✔	All	✔
32	✔	✔	✔	All	✔
33			✔	DEEOIC	
34	✔	✔	✔	DFEC	✔
35	✔	✔	✔	All	✔
36	✔	✔	✔	All	✔
37	✔	✔	✔	All	✔
38	✔	✔	✔	All	✔
40	✔	✔	✔	All	✔
41		✔	✔	DFEC	
42	✔	✔	✔	All	✔
43			✔	All	✔
44			✔	All	✔
46	✔	✔	✔	All	✔

Provider Type	NPI required?	Taxonomy required?	License/Certification required?	Applicable Program(s)	Self-Enrollment allowed? **
47	✔	✔	✔	DFEC	
50	✔	✔	✔	All	✔
51	✔	✔	✔	All	✔
52	✔	✔	✔	All	✔
53			✔	All	✔ for DEEOIC
55			✔	DFEC	
56			✔	DFEC	
57			✔	DFEC	
58			✔	DFEC	
59				DFEC	
60	✔	✔	✔	All	✔
61	✔	✔	✔	All	
62	✔	✔	✔	All	✔
63	✔	✔	✔	All	✔
65	✔	✔	✔	All	✔
66	✔	✔	✔	All	✔
67	✔	✔	✔	DFEC	
68	✔	✔	✔	All	✔
69	✔	✔	✔	All	✔
70	✔	✔	✔	All	✔
71	✔	✔	✔	All	✔
72	✔	✔	✔	All	✔
73	✔	✔	✔	All	✔
74	✔	✔	✔	All	✔
75	✔	✔	✔	All	✔

Provider Type	NPI required?	Taxonomy required?	License/Certification required?	Applicable Program(s)	Self-Enrollment allowed? **
76	✔	✔	✔	All	✔
77	✔	✔	✔	All	✔
78	✔	✔	✔	All	✔
80	✔	✔	✔	All	✔
88	✔	✔	✔	All	✔
89	✔	✔	✔	All	✔
90	✔	✔	✔	All	✔
92	✔	✔	✔	All	✔
93	✔	✔	✔	All	✔
94	✔	✔	✔	All	✔
95	✔			All	✔
96	✔	✔	✔	All	✔
97				All	✔
98				All	

** If Self-Enrollment is not allowed for a certain provider type, please contact 1-844-493-1966.