Bureau of Workers' Compensation

Request to Change Provider Information

Please print or type.
Submit the form to BWC in one of the following ways.
Email: to providerenrollment@bwc.ohio.gov
Fax: 614-621-1333
Mail: BWC Provider Enrollment Unit, P.O. Box 15249, Columbus, OH 43215-0249
Online: Log into your on-line provider account at bwc.ohio.gov and click on 'My Provider Info' to make changes.

Questions?
Call **1-800-477-2292** to reach BWC's Provider Contact Center

Points to review before completing this form

- You must determine if you are updating an individual person's provider number or a business/organizational provider number, and complete a separate form for each number to be updated.
- Business/Organization providers:
  - If you have a **new tax ID without change of ownership**, complete this form and send us a new W-9 Internal Revenue Service (IRS) form for our records. This form is found at **www.irs.gov/pub/irs-pdf/fw9.pdf**. **EXCEPTION: Group Practice business providers must submit new application.** Include the date former number became invalid, and the date new number became effective. (Note: no bills will be payable for dates of service after the termination date of the previous provider number).
  - If you are new owners of a tax ID already established in our database, please complete a new provider application (MEDCO-13 or MEDCO-13A) for our files to show authorized agreement signature and ownership information. You do not need to complete this form.

Date effective	BWC provider ID

Check record(s) below to update:

☐ Individual provider name	Provide SSN or NPI

▶▶ OR

☐ Business name	Provide Tax ID or NPI ***(Note: If multiple records exist under same Tax ID or NPI, all will all be updated when this identifier provided)***

Current owner name(s) **(Change in ownership requires a new application to be filed)**

New information

Change being requested ☐ New practice location ☐ Adding additional location ☐ Remove following location ☐ Other change requested (see below)

(Groups/Individuals only) street address *(Indicate the address where you render services, including suite, floor, etc. We will accept a P.O. Box only if you include additional street address information.)*

City, State, ZIP code

Telephone ( )	Fax ( )	E-mail address

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.)*

City, State, ZIP code

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.)*

City, State, ZIP code

Other change requested

Applicant or authorized personnel signature ***(Required)*** Reimbursement change information requires provider's signature	Title
Please print or type name	Date

Submitter contact information

Name	Phone	Email