Bureau of Workers' Compensation

Application for Provider Recertification

Provider Recertification

MEDCO-13B

Thank you for your commitment to treating Ohio's injured workers and for being a valued, certified-network provider. We recertify our provider network periodically and offer an online or paper application process for recertification. If you received a recertification letter from us to confirm your credentials, demographic information, and sign a new provider agreement, choose one of the two ways to submit your recertification application and supporting information:

1. Online at bwc.ohio.gov by accessing the *My Provider Info* web offering through your provider online account.
2. Print, complete and return this form along with all required provider documentation. Applications may be returned for missing information.

Visit us on the Internet at:

bwc.ohio.gov

Online recertification is easy and available through your secure online provider account. After logging in and making your demographic updates, click the recertification application option. If you don't have an online provider account, please visit bwc.ohio.gov to learn how to create one today.

If you choose to complete a paper application, print this form, complete all sections, and gather the required documents. Once you are finished, the MEDCO-13B and required documents may be faxed to 614-621-1333, emailed to providerenrollment@bwc.ohio.gov or mailed to BWC Provider Enrollment, P.O. Box 15249, Columbus, Ohio 43215-0249.

Important documentation

- Complete the recertification process within 30 days.
- Ensure you provide the individual provider or organization's authorized signature.
- Include all required documentation.
  - State licensure or accreditation/certification document.
  - Board specialty or chiropractic diplomate certificate (if applicable).
  - Drug Enforcement Administration registration (if applicable).
  - Workers' Compensation policy or attestation of no employees.
  - National Provider ID verification letter.
  - Internal Revenue Service (IRS) W-9

We will review your recertification submission and contact you if we need more information. Once our review is complete, you will receive a recertification confirmation letter. Please allow up to six weeks for processing.

Thank you for partnering with BWC in providing care for Ohio's injured workforce. If you have questions, please call us at 1-800-477-2292.

Bureau of Workers' Compensation

Application for Provider Recertification

Provider type: see requirements to submit based on your current provider type

For the following provider types, complete sections 1, 2, 3, and 4. Attach the 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 – certified or accredited by American board for certification in orthotics, prosthetics & pedorthics (ABC) or Board of certification/accreditation (BOC).
- **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 (Ph.D.) – 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 license
- **90** Ergonomist – CPE, CHFP, AEP, AHFP, CEA, CSP with ergonomics specialist designation, CIE, CIH, ATP, or RET

For the following provider types, complete sections 1, 4, and application contact information on 3. Attach the required documents.

- **01** Air ambulance – Private: license from Ohio state board of emergency medical, fire, and transportation services. Public/government: Medicare participation.
- **02** Ambulance/Ambulette service – Private: license from Ohio state board of emergency medical, fire, and transportation services. 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
- **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
- **19** Independent Diagnostic Testing Facility – Medicare participation
- **30** Home health agency – License from Ohio Dept of Health and Medicare participation
- **32** (HHA) Hospice – Ohio Department of Health license and Medicare participation
- **34** Hospital – General/acute – Medicare participation and Ohio Dept of Health license
- **35** Hospital – per diem services (detox inpatient stay) – Medicare participation and Ohio Dept of Health license
- **36** Hospital – Psychiatric – Medicare participation and Ohio Dept of Health license
- **37** Hospital – Rehabilitation/long-term acute hospital – CARF or Medicare participation and Ohio Dept of Health license
- **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 Dept of Health registration and Medicare 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

1. General information

MEDCO-13B

1	Current BWC provider number **(required)**	Date of birth	Tax identification number	Social Security number
2	Individual Name *(NOTE: Individuals are not linked to businesses in the BWC system)*			
	▶ ▶ OR			
3	Business Legal Name *(business name must appear as recognized by the IRS and on submitted W-9)*			W-9 shows 1099 address? ☐ Yes ☐ No *If no, attach address.*
4	Business - Doing Business As (DBA) name *(must appear as recognized by the IRS and on submitted W-9)*			
5	Business type (check one - **must match W-9 submitted**) ☐ Individual ☐ Sole proprietor ☐ Business (Corporation, LLC, S-Corp, Single member LLC, Partnership, Non-profit, etc.)			
6	NPI number (individual or organization)	Taxonomy code(s)		
7	Business owner names(s), define 100% of ownership, designate interest amount per owner. **If more than two owners, use separate page below.**			
8	☐ Check if no employees	Workers' compensation employer policy number, **required** if you have employees		
9	Practice location street address *(Indicate the address where you render services, including suite, floor, etc. Do not use P.O. Box.)* **Additional addresses listed 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

	Requirement/Credentials	Effective date	State	Number	Expiration
17	Drug Enforcement Administration number *(Please attach a copy of DEA registration).*				
18	List Medicare number as indicated under provider type requirement page. Hospitals must designate number matching type (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)*				
20	License #1				
21	License #2				
22	Other				

2. Individual provider information

23	List board specialty		Date certified
24	List board specialty		Date certified

	Education/training Program type	Institution name	Degree/Certification	Year
25				
26				

27	Foreign languages spoken			
28	Provider home address			
29	City		State	Nine-digit ZIP code

3. Provider information questions and answers **MEDCO-13B**

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
9. Have you ever had a conviction or plea of guilty to a criminal offense, other than as specified in Question 10 below? ☐ Yes ☐ No
10. Have you ever had 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. Have you ever had 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. Have you ever had 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	Title
Telephone number	Fax number
Email address	

BWC USE ONLY

Online account username

4. Provider application/agreement

MEDCO-13B

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 attests that it presently has and agrees to maintain professional malpractice and liability insurance (commercial liability insurance if applicable) at all times during the course of this contract. Provider agrees to provide proof of such coverage to BWC upon request.

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.

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 or authorized business personnel signature **(Must be a certifiable digital or pen signed signature)**	Title
Print or type name	Date

	Owner name	Ownership %
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Additional practice address

Street address			
City		State	ZIP code
County	Telephone	Fax number	
Office email			

Additional practice address

Street address			
City		State	ZIP code
County	Telephone	Fax number	
Office email			

Additional practice address

Street address			
City		State	ZIP code
County	Telephone	Fax number	
Office email			

Additional practice address

Street address			
City		State	ZIP code
County	Telephone	Fax number	
Office email			

Additional practice address

Street address		
City	State	ZIP code
County	Telephone	Fax number
Office email		

Additional practice address

Street address		
City	State	ZIP code
County	Telephone	Fax number
Office email		

Additional practice address

Street address		
City	State	ZIP code
County	Telephone	Fax number
Office email		

Additional practice address

Street address		
City	State	ZIP code
County	Telephone	Fax number
Office email		

Additional practice address

Street address		
City	State	ZIP code
County	Telephone	Fax number
Office email		

Additional practice address

Street address		
City	State	ZIP code
County	Telephone	Fax number
Office email		

Additional practice address

Street address		
City	State	ZIP code
County	Telephone	Fax number
Office email		

Additional practice address

Street address		
City	State	ZIP code
County	Telephone	Fax number
Office email		