



**U.S. Department of Labor - Office of Workers' Compensation Programs
Billing Agent/Clearinghouse Enrollment Template**

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

New Enrollment Update

1a. If Update, enter Provider ID

2. Individual Information (If you enroll using SSN)

2a. Last Name

2c. Middle Name

2b. First Name

2d. SSN

3. Organization Information

3a. Organization Name (Legal Business Name)

3b. Organization Business Name (Doing Business As)

3c. FEIN

4. Address

4a. Address Line 1

Address Line 2

4b. City/Town

4c. State/Province

4d. Zip Code

5. Phone Number

6. Fax Number

7. Email Address

8. EDI Submission Method (check all applicable)

Web Interactive

FTP Secure Batch

Web Batch

9. If selected FTP Secured Batch or Web Batch, provide EDI Contact Information (Leave it blank if it's same as above)

9a. Contact Title

9b. Last Name

9c. First Name

9d. Phone Number

9e. Fax Number

9f. Email Address

9g. Address Line 1

Address Line 2

9h. City/Town

9i. State/Province

9j. Zip Code

Signature: _____

Date: _____

Sign, date and mail or fax the form to the following address:

Provider Enrollment
Department of Labor - OWCP
P.O. Box 34690
San Antonio, TX 78265
Fax: 1-888-444-5335

(Incomplete forms will cause a delay in processing and are subject to return)