



Bureau of Workers' Compensation

30 W. Spring St.
Columbus, OH 43215-2256

Request to Change Provider Information

Instructions

- Please print or type.
- Return completed form to: Ohio Bureau of Workers' Compensation, Provider Enrollment Unit, P.O. Box 15249, Columbus, OH 43215-0249, or submit by fax: 614-621-1333

Questions?

Call **1-800-OHIOBWC** to reach BWC's provider relations department

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. Submit National Provider Identifier (NPI) verification if applicable.
- 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. 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	New tax identification number ☐ or Social Security number ☐ (Attach a copy of the IRS form W-9. This number will be used for IRS purposes).
Legal name associated with tax identification number (Must appear as recognized by the IRS)	
DBA name of group/business or individual provider name	
Business type ☐ Individual ☐ Sole proprietor ☐ Partnership ☐ Corporation ☐ S Corporation ☐ LLC ☐ Non-profit	
NPI number (attach Fox Systems, Inc. verification)	Taxonomy code (attach Fox Systems, Inc. verification)

Previous demographic information	Current BWC provider number	Date no longer valid	
	Previous owner name(s)		
	Practice location 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			

New information	New owner name(s)		
	Practice location 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			

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