GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers'
Compensation Program

DISTRICT OF COLUMBIA PUBLIC SECTOR WORKERS' COMPENSATION PROGRAM
PANEL OF HEALTHCARE PROVIDERS APPLICATION FOR
QUALIFIED HEALTH PROFESSIONALS

The following information is submitted for inclusion as a member of the District of Columbia's Public Sector Workers' Compensation Program's (Program) Panel of Healthcare Providers:

SECTION I. Applicant Information			
Applicant Name:		**Specialty:**	
Board Certification(s):			
State of Licensure:		**License No.:**	
State of Licensure:		**License No.:**	
State of Licensure:		**License No.:**	
DEA#:	**National Provider Identifier (NPI):**		
Are you a Nurse Practitioner or Physician Assistant? ☐ Yes ☐ No If yes, identify the Managed Care Organization with which you are affiliated:			
Languages spoken:			
Hospital Affiliations:			
Malpractice Insurance Carrier:		**Policy No.:**	
Sanctions:	**Pending Action(s):** ☐ Yes ☐ No	If yes, please provide a detailed account of the allegation(s) on a separate page.	
	Prior Adverse Action(s): ☐ Yes ☐ No	If yes, please attach a copy of the adverse decision.	
Malpractice Litigation:	Pending Action(s): Please provide a list of any pending malpractice claims, to include the basis for the cause of action, case caption, and tribunal location.		
	Prior Adverse Determination(s): Please attach copies of the verdict(s) and judgment(s).		
Would you be interested in providing Independent Medical Examination (IME) services: ☐ Yes ☐ No			

SECTION II. Practice Information			
Practice Name:			
Address:	Street:		
	City:	State:	Zip Code:
Telephone:		**Fax:**	

SECTION II. Practice Information (continued)		
Billing Contact Name:		
Billing Telephone Number:		
Email for Explanation of Remittance (EOR):		
Malpractice Insurance Provider:		**Policy No.:**
National Provider Identifier (NPI):		
Employer Identification No. (EIN):		

SECTION III. District of Columbia Office of the Chief Financial Officer (OCFO) vendor approval.	
Existing OCFO vendor approval:	☐ Yes ☐ No Attach IRS Form W-9

Applicant Certification:
As a member of the Program's Panel of Healthcare Providers, I will be subject to reporting, billing, and reimbursement rules and regulations as set forth in D.C. Official Code § 1-623.01 *et seq*. and D.C. Municipal Regulations Title 7, Chapter 1. I understand that ***PRIOR AUTHORIZATION IS REQUIRED FOR ALL TREATMENT EXCEPT IN THE CASE OF EMERGENCY CARE OR AS SET FORTH IN A SEPARATE PROVIDER AGREEMENT***. Additional information pertaining to the rights, duties, and obligations of a Panel member, including the PSWCP Provider Manual, may be published on the Healthcare Provider Information Page of the Office of Risk Management website (www.orm.dc.gov). I understand that it is my obligation as a Panel member to comply and remain up to date with all applicable rules and regulations. By my signature I certify that the information contained herein is true, correct, and complete, and I authorize the District of Columbia Office of Risk Management to verify this information.

Signature: _____ Date: _____

For Internal Program Use Only				
App. Received	App. Approval	OFCO Approval	250 Mail Code	Provider Notification