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 HEALTHCARE PROVIDER APPLICATION

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

SECTION I. Applicant Information			
Name:			
Address:	Street:		
	City:	State:	Zip Code:
Telephone:		**Fax:**	
Email:			
Languages Spoken:			
National Provider Identifier (NPI):			
Tax Identification No.:			
Insurance Provider:		**Policy No.:**	
Is the Applicant a Managed Care Organization as defined by D.C. Official Code § 1-623.01(18)**?** ☐ Yes ☐ No			
Are there multiple locations? If yes, please list below, using additional pages if needed. ☐ Yes ☐ No			
Location 2:	Street:		
	City:	State:	Zip Code:
Telephone:	Fax:	Tax ID:	
Location 3:	Street:		
	City:	State:	Zip Code:
Telephone:	Fax:	Tax ID:	

SECTION II: Practice Information	
Billing Contact Name:	
Billing Telephone Number:	
Email for Explanation of Remittance (EOR):	

TURN OVER FOR MORE INSTRUCTIONS

SECTION III. If Applicant is a Medical Group or Practice please list all affiliated physicians. If Applicant is a Managed Care Organization, nurse practitioners and physician assistants should also be listed. Use additional pages if necessary, or attach a roster of applicable persons.

Name	License No.	License Expiration Date	Specialty	NPI

SECTION IV. 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, the Applicant 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. It is understood that ***PRIOR AUTHORIZATION IS REQUIRED FOR ALL TREATMENT EXCEPT IN THE CASE OF EMERGENCY CARE OR AS SET FORTH IN A SEPARATE PROVIDER AGREEMENT***. ***PERSONS IDENTIFIED IN SECTION III ABOVE, MUST INDEPENDENTLY APPLY AND BE ADMITTED TO THE PROGRAM'S PANEL OF HEALTHCARE PROVIDERS FOR THEIR SERVICES TO BE REIMBURSABLE.*** 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). It is understood that all Panel members have an obligation 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, that I am authorized and empowered to submit this application on behalf of _____ _____, and I authorize the District of Columbia Office of Risk Management to verify this information.

Signature: _____ Date: _____

Printed Name: _____

Title: _____