Conduent Fiscal Agent Services

U.S. Department of Labor Provider

Address Change Form

Please complete all sections on this form.

Section A: General Information
Provider Name:
Provider Number:
Please check appropriate program: ☐ FECA (Federal Workers' Compensation Act) ☐ DEEOIC (Division of Energy Employees Occupational Illness Compensation) ☐ DCMWC (Division of Coal Mine Workers' Compensation)

Section B: Previous Address Information ☐ **Physical/Practice** ☐ **Billing/Remit**		
Street Address:		
City:	State:	Zip:
Phone: ( )		

Section C: New Address Information ☐ **Physical/Practice** ☐ **Billing/Remit**		
Street Address:		
City:	State:	Zip:
Phone: ( )		

Section D: Authorization	
Signature:	Date:
Print Name:	
Title:	

Return to:
DCMWC/Black Lung
P.O. BOX 8302
LONDON, KY 40742-8302