Department of Labor-OWCP
ELECTRONIC DATA INTERCHANGE

CONDUENT

PLEASE INDICATE YOUR CLASSIFICATION:

☐ Software Vend ☐ Switch Vend ☐ Provider ☐ **Clearinghouse** ☐ Billing Agent

A1.	Please indication classification information.		
Submitter/Vendor/Provider Name:			
Address:			
City, State, Zip:			
Telephone #:		FAX #:	
Provider Number:		EIN:	
Group Provider Number:		EMAIL ADDRESS:	
Provider Specialty:			

A2.	Please indicate contact information, if different from Submitter/Vendor/Provider Information in Section A1.		
Contact Name and Title:			
Business Address:			
City, State, Zip:			
Phone Number:		Fax Number:	
Email Address:			

A3.	If you have indicated that you are a Software Vendor in section A1, please provide the following information:				
Software Name:		Software Version:		Protocol:	
Do you currently have clients submitting to Conduent? ☐ Yes ☐ No					

A4.	Electronic Submission Method
Submitter Type:	☐ Vendor Software ☐ Clearinghouse ☐ Billing Agent
Format Type:	☐ Proprietary ☐ X12N
Transaction Type:	☐ Professional ☐ Dental ☐ Institutional ☐ HCFA ☐ UB
Submission Method:	☐ WEB ☐ NDM ☐ ASYNC

A5.	Electronic Report Retrieval
Are you interested in retrieving your transaction electronically?	☐ Yes ☐ No
Who will retrieve your reports?	☐ You ☐ Billing Agent ☐ Clearinghouse
Which reports would you like to access electronically?	☐ Functional Acknowledgement (997) ☐ Healthcare Claim Payment Advice (835)

Please return completed forms via Mail or FAX to: 1-800-309-6180
Department of Labor
Pharmacy Bill Processing, DCMWC
PO Box 8309
London, KY 40742-8309

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