



**Department of Labor-OWCP
ELECTRONIC DATA**

PLEASE INDICATE YOUR CLASSIFICATION:

Software Vender Switch Vender Provider Clearinghouse Billing Agent

| | | | | |
|---|---|-----------------------------|--|-----------|
| A1. | Please indicate 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 Vender 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 complete forms via Mail or FAX to 1-888-444-5335.
CONDUENT ENROLLMENT DEPARTMENT
US Department of Labor - OWCP
P.O. Box 8302
London, KY 40742-8302**

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