Department of Labor-OWCP
ELECTRONIC DATA INTERCHANGE

PLEASE INDICATE YOUR CLASSIFICATION:

Software Vender ☐ Switch Vender ☐ 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 complete forms via Mail or FAX to: 1-888-444-5335
CONDUENT ENROLLMENT DEPARTMENT
US Department of Labor
OWCP P.O. Box 8300 London, KY 40742-8300

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