



ACS 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:		
<input type="checkbox"/> FECA (Federal Workers' Compensation Act)		
<input type="checkbox"/> DEEOIC (Division of Energy Employees Occupational Illness Compensation)		
<input type="checkbox"/> DCMWC (Division of Coal Mine Workers' Compensation)		

Section B: Previous Address Information			<input type="checkbox"/> Physical/Practice	<input type="checkbox"/> Billing/Remit
Street Address:				
City:	State:	Zip:		
Phone: ()				

Section C: New Address Information			<input type="checkbox"/> Physical/Practice	<input type="checkbox"/> Billing/Remit
Street Address:				
City:	State:	Zip:		
Phone: ()				

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

Return to:
Enrollment Unit
DOL-Black Lung
PO Box 13200
Tallahassee, FL 32317-3200