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: ☐ 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:
Enrollment Unit
DOL-FECA
PO Box 14600
Tallahassee, Fl 32317