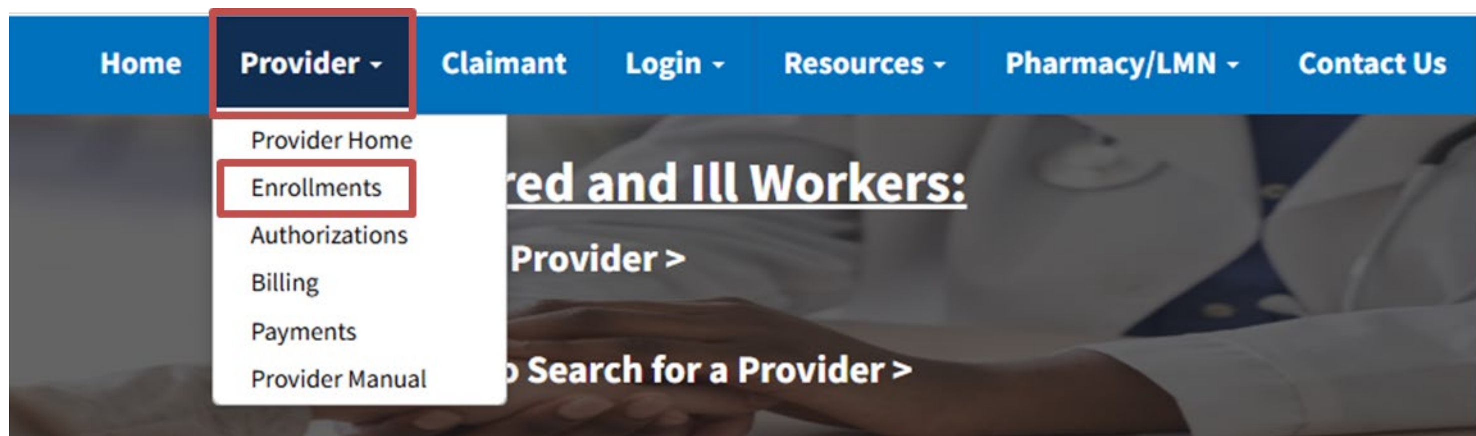
Resubmitting a Returned to Provider Enrollment Application

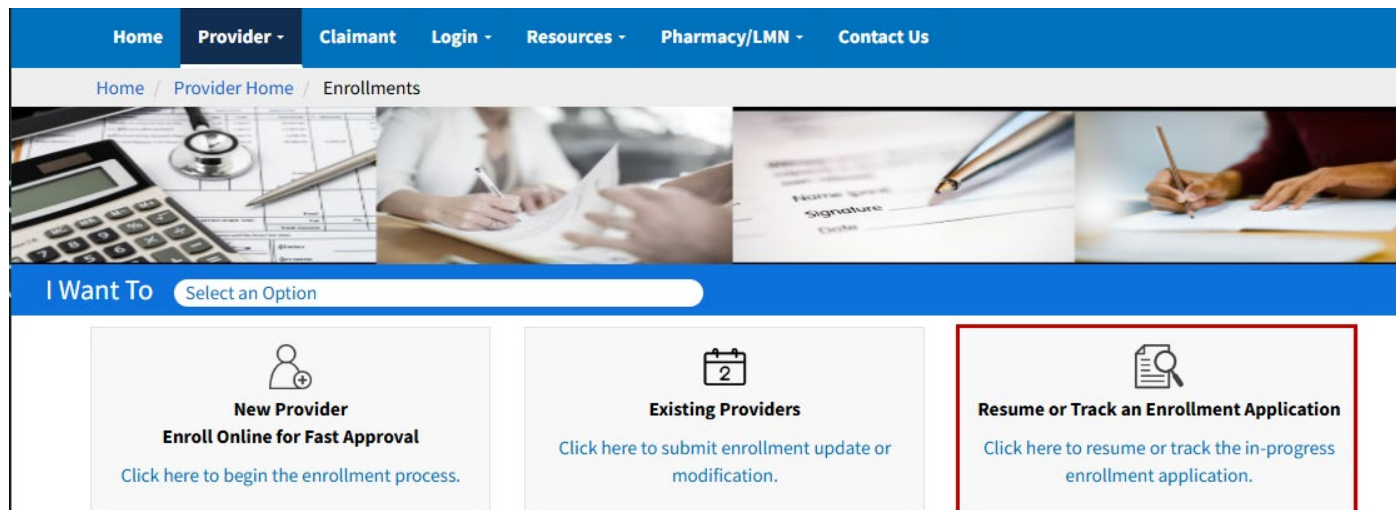
If a provider receives a Return to Provider (RTP) letter after submitting an enrollment application, the provider can make required updates to the initial application and resubmit it.

To make updates, complete the following steps:

1. From the WCMBP Portal, select the **Provider** tab, then select **Enrollments**.



2. Select the **Click here to resume or track the in-progress enrollment application** link.



Resubmitting a Returned to Provider Enrollment Application

3. Log in via OWCP Connect with the email address used during OWCP Connect registration.

United States Department of Labor
Office of Workers' Compensation Programs

OWCP
Office of Workers' Compensation Programs
Protecting Injured Workers Responsibly and Compassionately

Help | FAQ

OWCP Connect

Once your identity is verified, you can enroll and login to OWCP's Medical Bill Processing Portal to:

- Look up a claimant's case number
- Find a claimant's accepted diagnosis code(s)
- Check eligibility for specific procedures
- Submit prior authorization requests
- Submit/resubmit bills and adjustments
- View payment status
- View correspondence
- Utilize Fee Schedule Calculator
- Maintain provider enrollment information
- Add additional users who can use the portal

Existing User

Login Using Email Address:

LOGIN

Forgot password?

PASSWORD RESET

Change Email?

CHANGE EMAIL

New User

First time using OWCP Connect?
Create a new account here.

CREATE ACCOUNT

Information for Medical Providers

1. This process generally takes 3-5 minutes
2. Enrollment Tutorials (Click Here)
3. Contact Us (Click Here)

4. Enter the password created during OWCP Connect registration, then select **Submit**.

Login

Welcome Please verify your security image and enter password.

Security Image

Key Phrase tree

Password *

* Required Field

SUBMIT

Instructions

Please make sure that the image and key phrase match what you selected and entered when you created your account.

Please enter a new password that meets the criteria listed below, and click SUBMIT.

PASSWORD CRITERIA

Passwords must be at least 8 characters long, composed of characters from the each of the following four categories:

- Uppercase letters (including, but not limited to A, B, C, Y, Z, etc.)
- Lowercase letters (including, but not limited to a, b, c, y, z, etc.)
- Special Characters (limited to #, ?, !, @, $, %, ^, &, *, -)
- Numbers (including, but not limited to, 1, 2, 3, 4, 5, etc.)

Passwords cannot contain the text of User ID, first name, last name or street address.

Resubmitting a Returned to Enrollment Application

5. Determine if the **Application Number** and **SSN** or **FEIN** are known by the provider.
   - If known, proceed to slide five.
   - If not known, select the Application Number Lookup link.

eCAMS HCE

Profile: | External Links | Help | Logout

Track Application

Close | Submit

Please provide the Application Number and SSN/FEIN to track your application.

Need help finding the application number? Please select this link to look up and retrieve your application number.

Application Number: *

SSN/FEIN: *

6. To retrieve the **Application Number**, enter the National Provider Identifier (NPI) and Social Security Number (SSN) or Federal Employer Identification Number (FEIN) in the **National Provider Identifier** and **SSN/FEIN** fields.

eCAMS HCE

Profile: | External Links | Help | Logout

Track Application › Application Number Lookup

Close | Submit

Application Number Lookup

National Provider Identifier: *

SSN/FEIN: *

Zip Code:

Enrollment Applications

Note: Applications that are not yet approved are displayed below.

Resubmitting a Returned to Enrollment Application

7. To view the application number, select **Submit** above the **Application Number Lookup** section.

eCAMS™ HCE

Profile: | External Links | Help | Logout

Track Application › Application Number Lookup

Close | Submit

Application Number Lookup

National Provider Identifier: *

SSN/FEIN: *

Zip Code:

The system identifies the matching enrollment applications and displays the application's details in the **Enrollment Applications** section below the **Application Number** lookup section on the same page.

8. To access the application, select the **Application Number** link.

Note: Only those enrollment applications that have not been approved will display.

Enrollment Applications

Note: Applications that are not yet approved are displayed below.

Application Number	Provider Name	National Provider Identifier	SSN/FEIN	Address	Status	Created Date	Submitted Date
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	In Review	12/16/2024	12/16/2024

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SaveToCSV

Resubmitting a Returned to Enrollment Application

9. For providers who know their application number, in the **Application Number** field, enter the application number received during the initial enrollment.

eCAMS™ HCE

Profile: External Links Help Logout

Track Application

Close Submit

Please provide the Application Number and SSN/FEIN to track your application.

Need help finding the application number? Please select this link to look up and retrieve your application number.

Application Number: *

SSN/FEIN: *

10. In the **SSN/FEIN** field, enter the Social Security Number (SSN) or Federal Employer Identification Number (FEIN) used during the initial enrollment.

eCAMS™ HCE

Profile: External Links Help Logout

Track Application

Close Submit

Please provide the Application Number and SSN/FEIN to track your application.

Need help finding the application number? Please select this link to look up and retrieve your application number.

Application Number: *

SSN/FEIN: *

Resubmitting a Returned to Provider Enrollment Application

11. Select **Submit** to return to the application and make the necessary adjustments as indicated in the RTP letter or for any updates needed.

Close | **Submit**

Please provide the Application Number and SSN/FEIN to track your application.

Need help finding the application number? Please select this link to look up and retrieve your application number.

Application Number: *

SSN/FEIN: *

Note: When returning to the enrollment application, the status of all required steps will be displayed as **Incomplete**.

- Each required step must be opened to verify that the information is correct or make necessary adjustments.
- Selecting the caret within the **Required** column sorts each step by required or optional.
- Open each step, verify or adjust the information as needed, and then close the step.
- The step status will then be marked as Complete.

Close | Required Credentials | Purge

Enroll Provider -Individual

Business Process Wizard – Provider Enrollment (Individual). In order to submit your application, please click the last step for **Submit Enrollment Application for Review.**

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/30/2024	10/18/2024	Complete	
Step 2: Add Location	Required	07/30/2024	07/30/2024	Complete	
Step 3: Add Taxonomies	Required	07/30/2024	02/12/2025	Complete	
Step 4: Add Ownership Details	Optional	07/30/2024	02/12/2025	Complete	
Step 5: Add Professional Licenses and Certifications	Required	07/30/2024	10/18/2024	Complete	
Step 6: Add Identifiers	Optional	07/30/2024	07/30/2024	Complete	
Step 7: Add EDI Submission Method	Optional	07/30/2024	07/30/2024	Complete	
Step 8: Add EDI Submitter Details	Optional	07/30/2024	07/30/2024	Complete	
Step 9: Add EDI Contact Information	Optional	07/30/2024	07/30/2024	Complete	
Step 10: Add Payment Details	Required	07/30/2024	01/24/2025	Complete	
Step 11: Complete Provider Disclosure	Required	07/30/2024	10/18/2024	Complete	
Step 12: View/Upload Attachments	Optional	07/30/2024	07/30/2024	Complete	
Step 13: Submit Enrollment Application for Review	Required	07/30/2024	02/12/2025	Complete	

Resubmitting a Returned to Provider Enrollment Application

Note: After verifying, revising, or adding the required information for each step, submit the enrollment application as described in the final steps below.

12. Select **Submit Enrollment Application for Review**.

eCAMS HCE

Profile: | External Links | Help | Logout

Track Application > Individual Enrollment

Application Number: | Name: | Enrollment Type:

Close | Required Credentials | Purge

Enroll Provider -Individual

Business Process Wizard – Provider Enrollment (Individual). In order to submit your application, please click the last step for **Submit Enrollment Application for Review.**

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/30/2024	10/18/2024	Complete	
Step 2: Add Location	Required	07/30/2024	07/30/2024	Complete	
Step 3: Add Taxonomies	Required	07/30/2024	02/12/2025	Complete	
Step 4: Add Ownership Details	Optional	07/30/2024	02/12/2025	Complete	
Step 5: Add Professional Licenses and Certifications	Required	07/30/2024	10/18/2024	Complete	
Step 6: Add Identifiers	Optional	07/30/2024	07/30/2024	Complete	
Step 7: Add EDI Submission Method	Optional	07/30/2024	07/30/2024	Complete	
Step 8: Add EDI Submitter Details	Optional	07/30/2024	07/30/2024	Complete	
Step 9: Add EDI Contact Information	Optional	07/30/2024	07/30/2024	Complete	
Step 10: Add Payment Details	Required	07/30/2024	01/24/2025	Complete	
Step 11: Complete Provider Disclosure	Required	07/30/2024	10/18/2024	Complete	
Step 12: View/Upload Attachments	Optional	07/30/2024	07/30/2024	Complete	
Step 13: Submit Enrollment Application for Review	Required	07/30/2024	02/12/2025	Complete	

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13. Enter the first and last name in the **First Name** and **Last Name** fields.

Track Application > Individual Enrollment > Submit Enrollment

Application Number: | Name: | Enrollment Type: Individual

Final Submission

After you submit the enrollment, you cannot make further changes until your enrollment application is approved.

Confirm & Sign

I, the undersigned, certify to the following: I have read the contents of this application, and the information contained herein is true, correct, and complete.
I certify that I and my agents have currently in effect all necessary licenses, certifications, approvals, insurance, etc. required to properly provide the services and/or supplies for the OWCP in the state, county, locality, or jurisdiction where the services and/or supplies are provided. I will provide proof of such licenses, certifications, approvals, insurance, etc. upon the OWCP's request. I understand that any revocation, withdrawal, or non-renewal of necessary license, certification, approval, insurance, etc. required for me to properly provide services, shall be grounds for termination of enrollment/registration by the OWCP.
I authorize the OWCP to verify the information contained herein. I agree to notify the OWCP of any change in ownership, practice location and/or Final Adverse Action involving fraud or abuse within 30 days of the reportable event. In addition, I agree to notify the OWCP of any other changes to the information in this form within 90 days of the effective date of change.
I also certify that I am not currently sanctioned, suspended, debarred or excluded by any Federal or State Health Care Program, (e.g., Medicare, Medicaid, or any other Federal program), or otherwise prohibited from providing services to Medicare, Medicaid, or other Federal program beneficiaries nor are any owners, officers, or managing employees of the practice listed in this application.
I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to the Department of Labor, Office of Workers' Compensation Program (OWCP), or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of OWCP billing privileges, civil damages, and/or imprisonment.

I agree to abide by the OWCP regulations and program instructions that apply to me or to the organization listed in Section 3A of this enrollment form. I understand that payment of a claim by OWCP is conditioned upon the claim and the underlying transaction complying with state and federal laws (including, but not limited to, the Federal anti-kickback statute) and OWCP regulations, and program instructions.

First Name: * | Last Name: *

Title: | Signature Date: 07/30/2024 12:26:07

Resubmitting a Returned to Provider Enrollment Application

14. Optionally, complete the **Title** field with the title of the final submitter.

Track Application › Individual Enrollment › Submit Enrollment

Application Number: Name: Enrollment Type: Individual

Final Submission

After you submit the enrollment, you cannot make further changes until your enrollment application is approved.

Confirm & Sign

I, the undersigned, certify to the following: I have read the contents of this application, and the information contained herein is true, correct, and complete.
I certify that I and my agents have currently in effect all necessary licenses, certifications, approvals, insurance, etc. required to properly provide the services and/or supplies for the OWCP in the state, county, locality, or jurisdiction where the services and/or supplies are provided. I will provide proof of such licenses, certifications, approvals, insurance, etc. upon the OWCP's request. I understand that any revocation, withdrawal, or non-renewal of necessary license, certification, approval, insurance, etc. required for me to properly provide services, shall be grounds for termination of enrollment/registration by the OWCP.
I authorize the OWCP to verify the information contained herein. I agree to notify the OWCP of any change in ownership, practice location and/or Final Adverse Action involving fraud or abuse within 30 days of the reportable event. In addition, I agree to notify the OWCP of any other changes to the information in this form within 90 days of the effective date of change.
I also certify that I am not currently sanctioned, suspended, debarred or excluded by any Federal or State Health Care Program, (e.g., Medicare, Medicaid, or any other Federal program), or otherwise prohibited from providing services to Medicare, Medicaid, or other Federal program beneficiaries nor are any owners, officers, or managing employees of the practice listed in this application.
I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to the Department of Labor, Office of Workers' Compensation Program (OWCP), or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of OWCP billing privileges, civil damages, and/or imprisonment.

I agree to abide by the OWCP regulations and program instructions that apply to me or to the organization listed in Section 3A of this enrollment form. I understand that payment of a claim by OWCP is conditioned upon the claim and the underlying transaction complying with state and federal laws (including, but not limited to, the Federal anti-kickback statute) and OWCP regulations, and program instructions.

First Name: * Last Name: *

Title: Signature Date: 07/30/2024 12:26:07

15. To complete the re-submission of the enrollment application, select **Submit Enrollment**. This action will change the status of the enrollment application to **In Review**.

Confirm & Sign

I, the undersigned, certify to the following: I have read the contents of this application, and the information contained herein is true, correct, and complete.
I certify that I and my agents have currently in effect all necessary licenses, certifications, approvals, insurance, etc. required to properly provide the services and/or supplies for the OWCP in the state, county, locality, or jurisdiction where the services and/or supplies are provided. I will provide proof of such licenses, certifications, approvals, insurance, etc. upon the OWCP's request. I understand that any revocation, withdrawal, or non-renewal of necessary license, certification, approval, insurance, etc. required for me to properly provide services, shall be grounds for termination of enrollment/registration by the OWCP.
I authorize the OWCP to verify the information contained herein. I agree to notify the OWCP of any change in ownership, practice location and/or Final Adverse Action involving fraud or abuse within 30 days of the reportable event. In addition, I agree to notify the OWCP of any other changes to the information in this form within 90 days of the effective date of change.
I also certify that I am not currently sanctioned, suspended, debarred or excluded by any Federal or State Health Care Program, (e.g., Medicare, Medicaid, or any other Federal program), or otherwise prohibited from providing services to Medicare, Medicaid, or other Federal program beneficiaries nor are any owners, officers, or managing employees of the practice listed in this application.
I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to the Department of Labor, Office of Workers' Compensation Program (OWCP), or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of OWCP billing privileges, civil damages, and/or imprisonment.

I agree to abide by the OWCP regulations and program instructions that apply to me or to the organization listed in Section 3A of this enrollment form. I understand that payment of a claim by OWCP is conditioned upon the claim and the underlying transaction complying with state and federal laws (including, but not limited to, the Federal anti-kickback statute) and OWCP regulations, and program instructions.

First Name: * Last Name: *

Title: Signature Date: 07/30/2024 12:26:07

Privacy Act Statement

Collection of this information by OWCP is necessary for its administration of the Federal Employees' Compensation Act, the Black Lung Benefits Act, the Longshore and Harbor Workers' Compensation Act and the Energy Employees Occupational Illness Compensation Program Act, and is authorized under 20 CFR 10.800, 20 CFR 30.700, 20 CFR 702.145, 20 CFR 725.714 and 33 USC 918(b). The information provided will be used to ensure accurate payment of medical and vocational rehabilitation provider bills and is protected by the Privacy Act of 1974, as amended (5 USC 552a) in accordance with the following systems of records: DOL/GOVT-1, DOL/OWCP-4 DOL/OWCP-9 and DOL/OWCP-11, published in the Federal Register, Vol. 81, page 25766, April 29, 2016, or as updated and republished. Completion and submission of this form is voluntary; however, failure to provide the information (including SSN or EIN) will result in substantially delayed payment of bills. This information will be furnished to OWCP and its data processing contractors, and may also be disclosed to other federal and state agencies in connection with the administration of other programs, to the Department of Justice for litigation purposes, and to medical and other provider review boards. Additional disclosures may be made through the routine uses for information contained in the referenced systems of records.

Close Submit Enrollment