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Note: This guide is intended for Providers with an existing Provider Portal account.



Selecting Provider ID and Profile

1. Select the Provider ID from the **Available Provider IDs** drop-down.

Welcome to the WCMBP Provider Portal

eCAMSTM
HCE ✓
Powered by CNSI

Select a Provider ID Number to continue to the Provider Portal:

Available Provider IDs: 020211301

Go

A red circle with the number 1 and an arrow points to the dropdown menu of the Available Provider IDs field.

2. Select **Go**.

Welcome to the WCMBP Provider Portal

eCAMSTM
HCE ✓
Powered by CNSI

Select a Provider ID Number to continue to the Provider Portal:

Available Provider IDs: 020211301

Go

A red circle with the number 2 and an arrow points to the Go button.



Selecting Provider ID and Profile

3. Select the applicable profile from the **Profile** drop-down list (such as, EXT Provider File Maintenance).

Note: Choose the applicable profile to access the relevant functionalities of the provider portal.

Welcome to the Workers' Compensation Medical Bill Process System

eCAMS™
HCE ✓
Powered by CNSI

Select a profile to use during this session:

Profile: EXT Provider File Maintenance *

A red circle with the number 3 and an arrow points to the profile dropdown menu.

4. Select **Go**. You will be taken to the Provider Portal.

Welcome to the Workers' Compensation Medical Bill Process System

eCAMS™
HCE ✓
Powered by CNSI

Select a profile to use during this session:

Profile: EXT Provider File Maintenance *

A red circle with the number 4 and an arrow points to the Go button.




Updating Information

1. To navigate to the View/Update Provider Data screen, select the **Maintain Provider Information** link.

1



Resubmit Denied/Voided Bill
Retrieve Saved Bills
Manage Templates
Create Bills from Saved Templates
Claimant 
Eligibility Inquiry
Authorization 
On-line Authorization Submission
Provider 
Maintain Provider Information
HIPAA 
Submit HIPAA Batch Transaction
Retrieve HIPAA Batch Responses
SFTP User Details



Updating Basic Information

1. Select the **Step 1: Basic Information** link.

<input type="checkbox"/>	Step	Required
<input type="checkbox"/>	Step 1: Basic Information ← 1	Required
<input type="checkbox"/>	Step 2: Location	Required
<input type="checkbox"/>	Step 3: Taxonomies	Optional
<input type="checkbox"/>	Step 4: Ownership Details	Optional

2. Make necessary updates to any of the editable fields, then select **OK**.

Note: If this is the only step needing an update, proceed to the last step, **13. Submit Maintenance Request for Review**.

Provider Details

Provider Type: 25-Physician (MD) & Physician (DC) *

If you select "Other Provider" (96) or Non-Medical Vendor (53), please explain:

Program: DFEC DCMWC DEEOIC DLHWC

Provider Name(Organization Name): (as shown on Income Tax Return)

Organization Business Name: Federal Employer Identification Number(FEIN):

National Provider Identifier(NPI): Email Address:

Entity Type: C Corporation * If Other, please explain:

I do not wish to be included in an online searchable list of OWCP providers.

Reason:

Status: Approved

2 → OK Cancel



Updating Location

1. Select the **Step 2: Location** link.

<input type="checkbox"/>	Step	Required
<input type="checkbox"/>	Step 1: Basic Information	Required
<input type="checkbox"/>	Step 2: Location ← 1	Required
<input type="checkbox"/>	Step 3: Taxonomies	Optional
<input type="checkbox"/>	Step 4: Ownership Details	Optional
<input type="checkbox"/>	Step 5: Licenses and Certifications	Optional

2. To review the Physical and Mailing addresses, select the **Location Name** blue link.

<input type="checkbox"/>	Location Name	Location Details	Start Date	End Date	Status	Business Status
<input type="checkbox"/>	[Redacted]	[Redacted]	01/01/1964	12/31/2999	Approved	Active



Updating Location

3. Enter a **Contact Last Name**, **Contact First Name**, and **Phone Number**.

Note: In addition to reviewing the Physical and Mailing addresses, users will be required to enter this information.

Close Save

Location Details

Business Name: *

Contact Last Name: * Contact First Name: *

Phone Number: Fax Number:

Email Address:

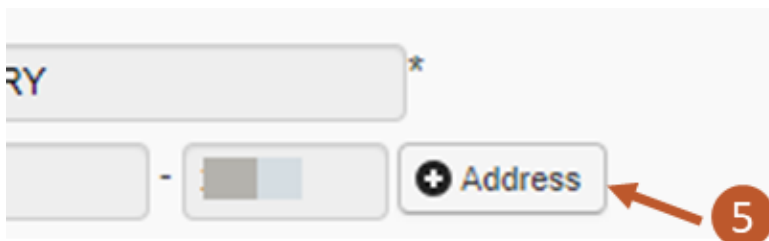
4. To change your Physical or Mailing address, select the applicable **Address Type** blue link at the bottom of the **Location Details** page.

<input type="checkbox"/>	Address Type ▲▼	
<input type="checkbox"/>	Mailing	<input type="text"/>
<input type="checkbox"/>	Physical	<input type="text"/>



Updating Location

5. Select **+ Address** at the bottom of the **Location Address** window.



6. Enter the new street address in **Address Line 1**, and **Address Line 2** or **Address Line 3**, if needed.

A screenshot of a form titled 'Address details'. The form contains several input fields: 'Address Line 1', 'Address Line 3', 'City/Town', 'State/Province', 'County', 'Country', and 'Zip Code'. The 'Address Line 1' field is highlighted with a red circle and arrow labeled '6'. Below the 'Address Line 1' field is the instruction '(Enter Street Address or PO Box Only)'. At the bottom right of the form is a 'Validate Address' button.



Updating Location

7. Enter the **Zip Code** of the new address.

The screenshot shows the 'Address details' form with the following fields: Address Line 1 (with a subtext '(Enter Street Address or PO Box Only)'), Address Line 3, City/Town, State/Province, County, Country, and Zip Code. A red circle with the number '7' and an arrow points to the Zip Code input field. A '+ Validate Address' button is located to the right of the Zip Code field.

8. Select **+ Validate Address**.

Note: If the address is valid, the City/Town, State/Province, County, and Country fields auto-populate.

The screenshot shows the 'Address details' form with the same fields as the previous image. A red circle with the number '8' and a downward arrow points to the '+ Validate Address' button. The City/Town, State/Province, County, and Country fields are now populated with data.



Updating Location

9. Once the system has validated the address, select **OK** at the bottom right of the screen.

The screenshot shows a form titled "Address details" with the following fields: "Address Line 1" (with a subtext "(Enter Street Address or PO Box Only)"), "Address Line 3", "City/Town", "State/Province", "County", "Country", and "Zip Code". A "Validate Address" button is located at the bottom right of the form. To the right of the form, a red circle containing the number "9" has a red arrow pointing down to the "OK" button in a dialog box.

10. After reviewing and entering the required information, select **Save**.

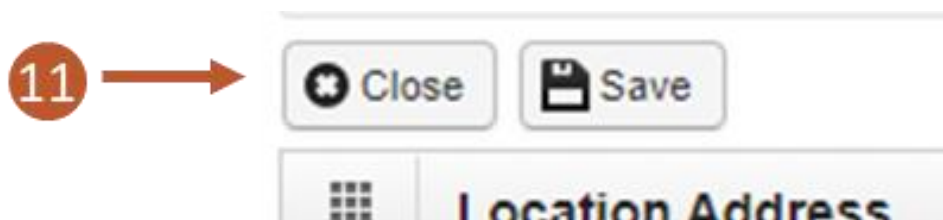
The screenshot shows a dialog box titled "Location Address" with "Close" and "Save" buttons. A red circle containing the number "10" has a red arrow pointing left to the "Save" button.



Updating Location

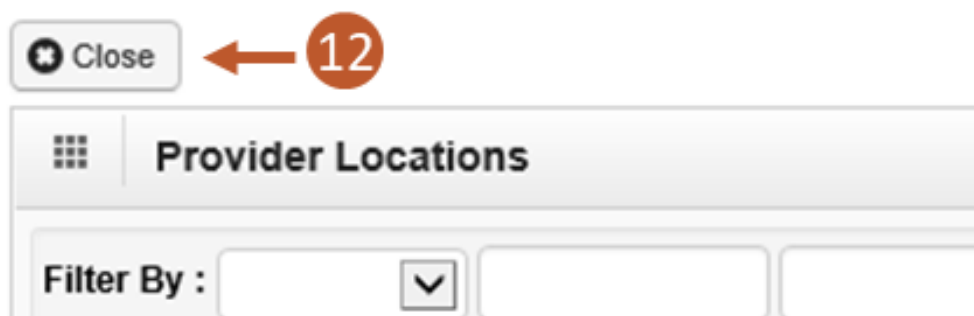
11. Select **Close**.

Note: On the **Provider Location** list page, if there is a data change in location, there will be two records on the **Provider Location** list page (one “Approved” and one “In Review”). Once the updated location is approved, the previously added location will be replaced with the new one.



12. Select **Close** again on the **Provider Locations** list page.

Note: If this is the only step that needs an update, proceed to the last step, **13. Submit Maintenance Request for Review.**





Updating Taxonomies

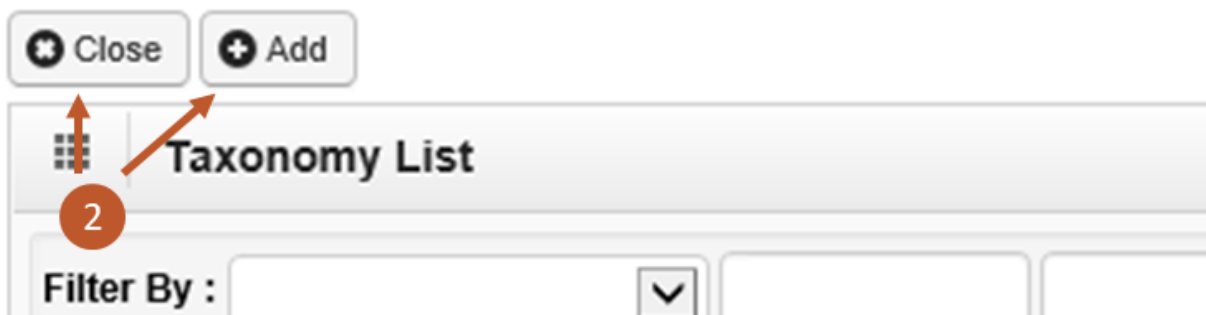
1. Select the **Step 3: Taxonomies** link.

Note: Depending on the Provider Type assigned during enrollment, this step may be required.

<input type="checkbox"/>	Step	Required	Last
<input type="checkbox"/>	Step 1: Basic Information	Required	05/0
<input type="checkbox"/>	Step 2: Location	Required	05/0
<input type="checkbox"/>	Step 3: Taxonomies ← 1	Required	
<input type="checkbox"/>	Step 4: Ownership Details	Optional	

2. Review the Taxonomy information. If additional taxonomies need to be added, select **+ Add**. Otherwise, select **Close**.

Note: If this is the only step needing an update, proceed to the last step, **13. Submit Maintenance Request for Review**.





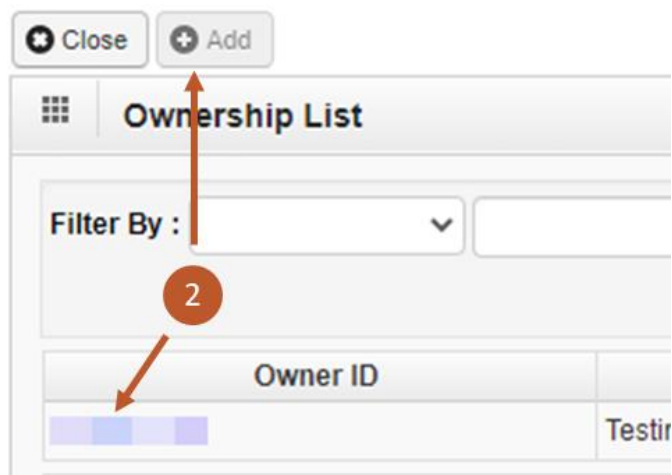
Updating Ownership Details

1. Select the **Step 4: Ownership Details** link.

<input type="checkbox"/>	Step	Required	Last
<input type="checkbox"/>	Step 1: Basic Information	Required	05/0
<input type="checkbox"/>	Step 2: Location	Required	05/0
<input type="checkbox"/>	Step 3: Taxonomies	Required	
<input type="checkbox"/>	Step 4: Ownership Details	Optional	

2. Either select the **Owner ID** link to make changes or select **+ Add** to add Ownership Details.

Note: If this is the only step needing an update, proceed to the last step, **13. Submit Maintenance Request for Review.**





Updating Licenses and Certifications

1. Select the **Step 5: Add Professional Licenses and Certifications** link.

Note: For Group Practice and Facility, Agency, Organization, and Institution Providers, this step is titled **Step 5: Add Business Licenses and Certifications**.

Note: This step is not required for Group Practice Providers.

Step	Required
Step 1: Provider Basic Information	Required
Step 2: Add Location	Required
Step 3: Add Taxonomies	Required
Step 4: Add Ownership Details	Optional
Step 5: Add Professional Licenses and Certifications	Required
Step 6: Add Identifiers	Optional
Step 7: Add EDI Submission Method	Optional

2. To update the license or certification, select either the **License** link or the **Certification** link.

Note: The **Add** button is available to add a new license number and information.

License Category	License/Certification Number	License/Certification Type	Issued State	Initial Issue Date	Expiration Date	Status	Operational Status	Inactivation Date
License				05/18/1984	05/12/2020	APPROVED	Active	
Certification				07/31/2019	12/31/2999	APPROVED	Active	



Updating Licenses and Certifications

3. Update the following information:

- Name
- License or Certification Type
- License or Certification Number
- Initial Issue Date
- Expiration Date
- Issued State
- Issuer Agency
- Web Link (where your license or certification can be verified)

Close Save

Manage Professional License/Certification

- Please provide all professional license/certification required by your State to perform the service under your Provider Type.
- OWCP will verify all your professional license/certification with your State's license issuer agency before your enrollment can be approved.
- After your enrollment is approved, you are responsible to keep your professional license/certification information up to date.
- Expired license/certification will cause the termination of the provider status.
- If you have a renewed professional license/certification under a different number, please make sure to enter it using the exact same License/Certification Type.

Status: In Review

C-Certification
 L-License
 N-License or Certification not required

Name: *

License or Certification Type: * Licence/Certification #: *

Initial Issue Date: * Expiration Date: *

Issued State: * Issuer Agency: *

Web Link: *



Updating Licenses and Certifications

4. After updating this information, select **Save**.

Close **Save** ← 4

Manage Professional License/Certification

- Please provide all professional license/certification required by your State to perform the service under your Provider Type.
- OWCP will verify all your professional license/certification with your State's license issuer agency before your enrollment can be approved.
- After your enrollment is approved, you are responsible to keep your professional license/certification information up to date.
- Expired license/certification will cause the termination of the provider status.
- If you have a renewed professional license/certification under a different number, please make sure to enter it using the exact same License/Certification Type.

Status: In Review

C-Certification
 L-License
 N-License or Certification not required

Name: Test Provider *

License or Certification Type: State * Licence/Certification #: *

Initial Issue Date: 12/06/1991 * Expiration Date: 03/31/2023 *

Issued State: Kentucky * Issuer Agency: *

Web Link: *

5. After saving the update, select **Close**.

Note: This is an optional step for Group Practices, and the verbiage on this step for Group Practices is different.

Close **Save**

Manage Professional License/Certification

5 ↑

- Please provide all professional license/certification required by your State to perform the service under your Provider Type.
- OWCP will verify all your professional license/certification with your State's license issuer agency before your enrollment can be approved.
- After your enrollment is approved, you are responsible to keep your professional license/certification information up to date.
- Expired license/certification will cause the termination of the provider status.
- If you have a renewed professional license/certification under a different number, please make sure to enter it using the exact same License/Certification Type.

Status: In Review

C-Certification
 L-License
 N-License or Certification not required

Name: Test Provider *

License or Certification Type: State * Licence/Certification #: *

Initial Issue Date: 12/06/1991 * Expiration Date: 03/31/2023 *

Issued State: Kentucky * Issuer Agency: *

Web Link: *



Updating Licenses and Certifications

- If multiple licenses or certifications are listed on the **Licenses/Certification List** page, then follow *Steps 2-5* for each item listed to complete the update.

The screenshot shows the 'License/Certification List' interface. At the top, there are 'Close' and 'Add' buttons. Below them is a filter section with 'Filter By' and 'And Operational Status' dropdowns, and buttons for 'Clear Filter', 'Save Filter', and 'My Filters'. The main table has columns for License Category, License/Certification Number, License/Certification Type, Issued State, Initial Issue Date, Expiration Date, Status, Operational Status, and Inactivation Date. Two rows are visible: 'License' and 'Certification'. A red circle with the number '6' and an arrow points to the 'Certification' row.

License Category	License/Certification Number	License/Certification Type	Issued State	Initial Issue Date	Expiration Date	Status	Operational Status	Inactivation Date
License				05/18/1984	05/12/2020	APPROVED	Active	
Certification				07/31/2019	12/31/2999	APPROVED	Active	

- After updating all licenses and certifications, select **Close** on the **Licenses/Certification List** page to return to the list of steps.

Note: If this is the only step that needs an update, proceed to the last step, **13. Submit Maintenance Request for Review.**

The screenshot shows the 'License/Certification List' interface. At the top, there are 'Close' and 'Add' buttons. Below them is a filter section with 'Filter By' and 'And Operational Status' dropdowns, and buttons for 'Clear Filter', 'Save Filter', and 'My Filters'. The main table has columns for License Category, License/Certification Number, License/Certification Type, Issued State, Initial Issue Date, Expiration Date, Status, Operational Status, and Inactivation Date. Two rows are visible: 'License' and 'Certification'. A red circle with the number '7' and an arrow points to the 'Close' button at the top left.

License Category	License/Certification Number	License/Certification Type	Issued State	Initial Issue Date	Expiration Date	Status	Operational Status	Inactivation Date
License				05/18/1984	05/12/2020	APPROVED	Active	
Certification				07/31/2019	12/31/2999	APPROVED	Active	



Updating Identifiers

1. Select the **Step 6: Add Identifiers** link.

Step	Required
Step 1: Provider Basic Information	Required
Step 2: Add Location	Required
Step 3: Add Taxonomies	Required
Step 4: Add Ownership Details	Optional
Step 5: Add Professional Licenses and Certifications	Required
Step 6: Add Identifiers ← 1	Optional
Step 7: Add EDI Submission Method	Optional

2. To add additional identifiers, select **Add**.

If adding identifiers, enter the required information in the **Add New Identifier** window, then select **OK**.

Close Add → Required Credentials

Provider Identifiers

Filter By: [dropdown] [input] [input] And [input]

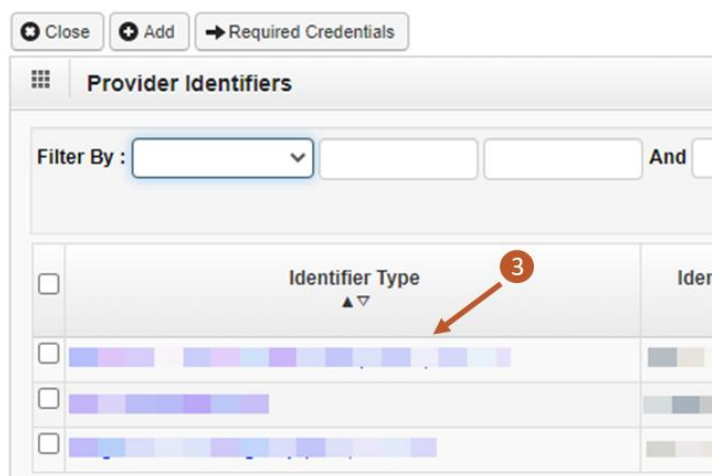
<input type="checkbox"/>	Identifier Type ▲▼	Iden
<input type="checkbox"/>	[Progress bar]	[Progress bar]
<input type="checkbox"/>	[Progress bar]	[Progress bar]
<input type="checkbox"/>	[Progress bar]	[Progress bar]



Updating Identifiers

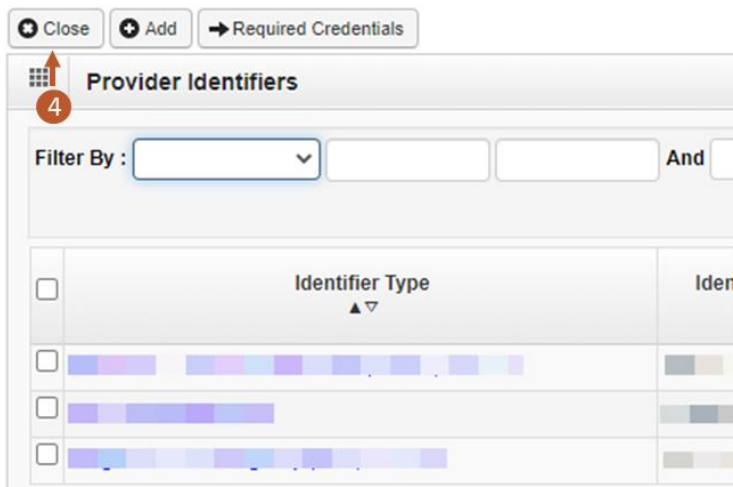
- To update the respective identifier, select the **Identifier Type** link.

If making updates to identifiers, once updated select **Save** and return to the list of steps.



- After saving the update, select **Close**.

Note: If this is the only step needing an update, proceed to the last step, **13. Submit Maintenance Request for Review**.





Updating EDI Submission Method

1. Select the **Step 7: EDI Submission Method** link.

<input type="checkbox"/>	Step 7: EDI Submission Method ← 1	Optional
<input type="checkbox"/>	Step 8: EDI Submitter Details	Required
<input type="checkbox"/>	Step 9: EDI Contact Information	Required

2. To add an EDI Submission Method, select **Add**.

If adding an EDI Submission Method, select the preferred mode of submission in the **EDI Submission Method** window, then select **OK** in the **Add New Identifier** window.

Close Add ← 2

EDI Submission Method

Filter By : [] And []

EDI Submission Method
▲▼

Web Batch, Billing Agent/Clearinghouse, FTP Secured Batch, Web Interactive



Updating EDI Submission Method

3. Select the **EDI Submission Method** link to update previously selected modes of submission.

If making updates to previously selected modes of submission, select **OK** and return to the list of steps.

The screenshot shows a web interface for updating the EDI Submission Method. At the top, there are 'Close' and 'Add' buttons. Below them is a header 'EDI Submission Method'. A 'Filter By' section contains two dropdown menus and an 'And' button. The main content area is a table with two rows. The first row is 'EDI Submission Method' with a dropdown arrow and a red circle with the number 3 pointing to it. The second row is 'Web Batch, Billing Agent/Clearinghouse, FTP Secured Batch, Web Interactive' with a blue link and a checkbox.

4. After saving the update, select **Close**.

Note: If this is the only step needing an update, proceed to the last step, **13. Submit Maintenance Request for Review.**

The screenshot shows the same web interface as the previous one. A red circle with the number 4 points to the 'Close' button at the top left of the interface.



Updating EDI Submitter Details

1. Select the **Step 8: EDI Submitter Details** link.

Note: This step is marked as “Required” only if Billing Agent or Clearinghouse was selected as an EDI Submission Method in the **EDI Submission Method** step; otherwise, it would be marked as “Optional”.

<input type="checkbox"/>	Step 7: EDI Submission Method	Optional
<input type="checkbox"/>	Step 8: EDI Submitter Details ← 1	Required
<input type="checkbox"/>	Step 9: EDI Contact Information	Required

2. To add a Billing Agent or Clearinghouse, select **Add**.

If adding an EDI Submission Details, include the Billing Agent or Clearinghouse OWCP ID, Start and End dates, and select **OK** on the **Associate Billing Agent/Clearinghouse** window.

Note: If this is the only step needing an update, proceed to the last step, **13. Submit Maintenance Request for Review**.

Close Add ← 2

Billing Agent/Clearinghouse/Submitter List

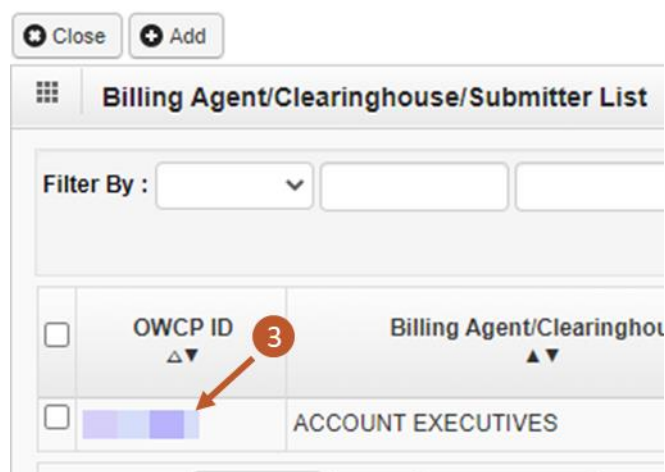
Filter By : [dropdown] [input] [input]

<input type="checkbox"/>	OWCP ID ▲▼	Billing Agent/Clearinghouse ▲▼
<input type="checkbox"/>		ACCOUNT EXECUTIVES



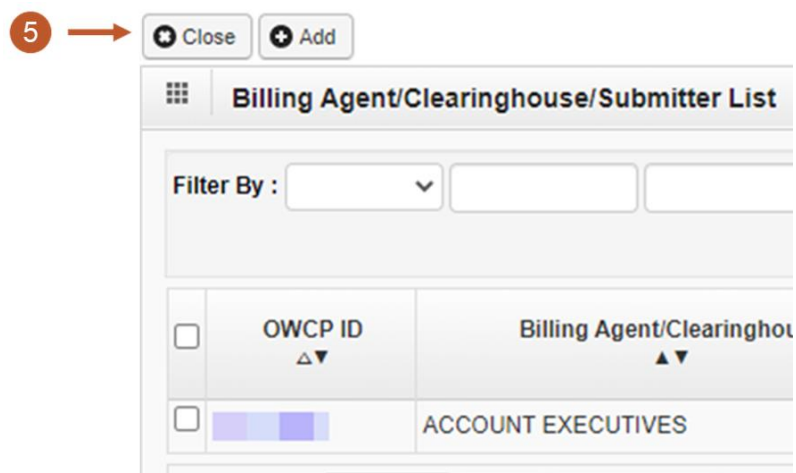
Updating EDI Submitter Details

3. Select the **OWCP ID** link to update the EDI Submitter Details.
4. After making updates to the Billing Agent or Clearinghouse Submitter, select **Save** on the **Manage Billing Agent/Clearinghouse Association** page.



5. After saving the update, select **Close**.

Note: If this is the only step needing an update, proceed to the last step, **13. Submit Maintenance Request for Review.**





Updating EDI Contact Information

1. Select the **Step 9: EDI Contact Information** link.

Note: This step is marked as “Required” only if Web Batch or FTP Secured Batch was selected as an EDI Submission Method in the **EDI Submission Method** step.

<input type="checkbox"/>	Step 7: EDI Submission Method	Optional
<input type="checkbox"/>	Step 8: EDI Submitter Details	Required
<input type="checkbox"/>	Step 9: EDI Contact Information ← 1	Required

2. To add EDI contacts, select **Add**.

If adding a contact, enter the required information in the **Add EDI Contact Information** window, then select **OK**.

<input type="checkbox"/>	Contact Title ▲▼	Contact Name ▲▼
<input type="checkbox"/>		ttt, IIII



Updating EDI Contact Information

3. To update the respective contact information, select the **Contact Title** links.
4. After making updates to the contact, select **Save**.

Close Add

EDI Contact Information List

Filter By : [dropdown] [input] [input]

<input type="checkbox"/>	Contact Title ▲▼	Contact Name ▲▼
<input type="checkbox"/>	← 3	ttt, llll

5. After saving the update, select **Close**.

Note: If this is the only step needing an update, proceed to the last step, **13. Submit Maintenance Request for Review.**

Close Add

EDI Contact Information List

5

Filter By : [dropdown] [input] [input]

<input type="checkbox"/>	Contact Title ▲▼	Contact Name ▲▼
<input type="checkbox"/>		ttt, llll



Updating Payment Details

1. Select the **Step 10: Payment Details** link.

Note: *If enrolled as a Group Provider*, an additional step is included prior to this one to add or associate “Servicing Providers.” The instructions for updating that step are included after the “Submit Maintenance Request for Review” step.

<input type="checkbox"/>	Step 10: Payment Details ← 1	Required	
<input type="checkbox"/>	Step 11: Complete Provider Disclosure	Required	
<input type="checkbox"/>	Step 12: View/Upload Attachments	Optional	
<input type="checkbox"/>	Step 13: Submit Maintenance Request for Review	Required	

2. To add payment details, if currently no payment details are listed, select **Add**. Then enter the required information in the **Payment Details** window and select **OK**.

The screenshot shows a window titled "Payment Details" with a "Close" button and an "Add" button. A red arrow with the number "2" points to the "Add" button. Below the buttons is a "Filter By:" dropdown menu. A table below the filter shows a list of accounts with columns for "Account Number" and "Account Type".

<input type="checkbox"/>	Account Number ▲▼	Account Type ▲▼	
<input type="checkbox"/>	*****2139	Checking	boa



Updating Payment Details

- To update the respective payment details, select the **Account Number** link.

After making updates to the payment details, select **OK**.

The screenshot shows a web interface for updating payment details. At the top, there are 'Close' and 'Add' buttons. Below them is a 'Payment Details' header with a grid icon. A 'Filter By' section contains three input fields. The main table has two columns: 'Account Number' and 'Account Type'. The first row shows a checkbox, the account number '****2139', and the account type 'Checking'. A red arrow points to the account number, and a red circle with the number '3' is next to it, indicating the step to click on the account number.

- After selecting **OK**, select **Close**.

Note: If this is the only step needing an update, proceed to the last step, **13. Submit Maintenance Request for Review**.

This screenshot is identical to the previous one, but with a red arrow pointing to the 'Close' button at the top left of the form, and a red circle with the number '4' next to it, indicating the final step to click on the Close button.



Complete Provider Disclosure

1. Select the **Step 11: Complete Provider Disclosure** link.

<input type="checkbox"/>	Step 10: Payment Details	Required	
<input type="checkbox"/>	Step 11: Complete Provider Disclosure ← 1	Required	
<input type="checkbox"/>	Step 12: View/Upload Attachments	Optional	
<input type="checkbox"/>	Step 13: Submit Maintenance Request for Review	Required	

2. Update the answers to the two questions on the Provider Disclosure page and provide comments if necessary.

Close Save

Provider Disclosure

If you answer Yes to the first Disclosure question, provide details including type of action, Agency undertaking adverse action and date of action

Question	Answer	Comments
Within ten years of the date of this statement have you or any individual listed on this application had an action related to fraud or abuse in a government program taken against him or her resulting in (1) a felony or misdemeanor conviction; (2) a liability finding in civil proceedings; or (3) a settlement entered into in lieu of conviction?	No	
(Required for FECA providers) For Provider Type "Medical Supplies/Durable Medical Equipment (DME) / Prosthetics / Orthotics" (75) only: Are you an accredited DMEPOS supplier enrolled with Medicare? If Yes; provide the phone number that you used in your Medicare DMEPOS enrollment.	No	



Complete Provider Disclosure

3. Select **Save**.

The screenshot shows the 'Provider Disclosure' form. At the top left, there are two buttons: 'Close' and 'Save'. A red circle with the number '3' is positioned above the 'Save' button, with a red arrow pointing to it. Below the buttons is a table with two rows of questions. The first row asks about actions related to fraud or abuse in a government program. The second row asks about Medicare enrollment for FECA providers. Both rows have a 'No' dropdown menu in the 'Answer' column and a text input field in the 'Comments' column.

Question	Answer	Comments
Within ten years of the date of this statement have you or any individual listed on this application had an action related to fraud or abuse in a government program taken against him or her resulting in (1) a felony or misdemeanor conviction; (2) a liability finding in civil proceedings; or (3) a settlement entered into in lieu of conviction?	No	
(Required for FECA providers) For Provider Type "Medical Supplies/Durable Medical Equipment (DME) / Prosthetics / Orthotics" (75) only: Are you an accredited DMEPOS supplier enrolled with Medicare? If Yes, provide the phone number that you used in your Medicare DMEPOS enrollment.	No	

4. Select **Close**.

The screenshot shows the 'Provider Disclosure' form. At the top left, there are two buttons: 'Close' and 'Save'. A red circle with the number '4' is positioned above the 'Close' button, with a red arrow pointing to it. Below the buttons is a table with two rows of questions. The first row asks about actions related to fraud or abuse in a government program. The second row asks about Medicare enrollment for FECA providers. Both rows have a 'No' dropdown menu in the 'Answer' column and a text input field in the 'Comments' column.

Question	Answer	Comments
Within ten years of the date of this statement have you or any individual listed on this application had an action related to fraud or abuse in a government program taken against him or her resulting in (1) a felony or misdemeanor conviction; (2) a liability finding in civil proceedings; or (3) a settlement entered into in lieu of conviction?	No	
(Required for FECA providers) For Provider Type "Medical Supplies/Durable Medical Equipment (DME) / Prosthetics / Orthotics" (75) only: Are you an accredited DMEPOS supplier enrolled with Medicare? If Yes, provide the phone number that you used in your Medicare DMEPOS enrollment.	No	



Viewing and Uploading Attachments

1. To upload any required attachments, select the **Step 12: View/Upload Attachments** link.

<input type="checkbox"/>	Step 10: Payment Details	Required	
<input type="checkbox"/>	Step 11: Complete Provider Disclosure	Required	
<input type="checkbox"/>	Step 12: View/Upload Attachments ← 1	Optional	
<input type="checkbox"/>	Step 13: Submit Maintenance Request for Review	Required	

2. To begin uploading attachments, select **Upload Attachments**.

Close Upload Attachments → Required Credentials

Attachment List

<input type="checkbox"/>	Repository Key	File Name
<input type="checkbox"/>		DFEC Surgical Package Authorization Request.pdf
<input type="checkbox"/>		Provider ACH Form.pdf
<input type="checkbox"/>		Home Health - DEEOIC-Authorization Request.pdf



Viewing and Uploading Attachments

3. To view previously uploaded attachments, select the **Repository Key** link.

Close Upload Attachments Required Credentials

	Repository Key	File Name
<input type="checkbox"/>		DFEC Surgical Package Authorization Request.pdf
<input type="checkbox"/>	Repository Key	Provider ACH Form.pdf
<input type="checkbox"/>		Home Health - DEEOIC-Authorization Request.pdf

4. Select **Close**.

Close Upload Attachments Required Credentials

	Repository Key	File Name
<input type="checkbox"/>		DFEC Surgical Package Authorization Request.pdf
<input type="checkbox"/>		Provider ACH Form.pdf
<input type="checkbox"/>		Home Health - DEEOIC-Authorization Request.pdf



Submit Maintenance Request for Review

1. As a required step, to submit the updates for review, select the **Step 13: Submit Maintenance Request for Review** link.

<input type="checkbox"/>	Step 10: Payment Details	Required
<input type="checkbox"/>	Step 11: Complete Provider Disclosure	Required
<input type="checkbox"/>	Step 12: View/Upload Attachments	Optional
<input type="checkbox"/>	Step 13: Submit Maintenance Request for Review	Required

2. On the **Final Modification Submission** page, carefully read the instructions, then verify the pre-populated **First Name** and **Last Name**. **Note:** The provider has the option to edit the first name and last name fields on the Final Modification Submission page before submitting the modification in case there is an error or a need for correction.

Final Modification Submission

Instructions for submitting modification:

Note: When updating license details

1. If your licensing agency does not allow online verification free of charge, please upload your current license as your business status is at risk of being terminated for expired licenses.
2. After you submit the modification, you cannot make further changes until your modification application is approved.
3. You must press **SUBMIT MODIFICATION** for your update to be reviewed.

Confirm and 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

First Name: Last Name:

Title: Signature Date: 10/31/2023

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 910(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.



Submit Maintenance Request for Review

3. (Optional) Enter the **Title** of the Final Modification Submitter.

Final Modification Submission

Instructions for submitting modification:

Note: When updating license details

1. If your licensing agency does not allow online verification free of charge, please upload your current license as your business status is at risk of being terminated for expired licenses.
2. After you submit the modification, you cannot make further changes until your modification application is approved.
3. You must press **SUBMIT MODIFICATION** for your update to be reviewed.

Confirm and 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.

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First Name: Last Name:

Title: Signature Date: 10/31/2023

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4. Select **Submit Modification**.

Note: Additional modifications to the information are not allowed until after the modification submission has been reviewed by Acentra Health staff.

Final Modification Submission

Instructions for submitting modification:

Note: When updating license details

1. If your licensing agency does not allow online verification free of charge, please upload your current license as your business status is at risk of being terminated for expired licenses.
2. After you submit the modification, you cannot make further changes until your modification application is approved.
3. You must press **SUBMIT MODIFICATION** for your update to be reviewed.

Confirm and 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, delisted or excluded by any Federal or State Health Care Program, (e.g. Medicare, Medicaid, or any other Federal program), or otherwise

First Name: Last Name:

Title: Signature Date: 10/31/2023

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.



Submit Maintenance Request for Review

5. The system shows the message that confirms the modification request has been submitted for review.
- Select **OK**.

The screenshot shows the 'Final Modification Submission' page in the Provider Portal. A red box highlights a confirmation message from 'sit.wcmbp.com says' that reads: 'The modification request has been submitted for review. Please check this Web site to verify the status of your request.' Below the message is an 'OK' button, which is circled in red with the number '5'. The page also contains instructions for submitting modifications, a 'Confirm & Sign' section with a signature line, and a 'Privacy Act Statement' at the bottom.

Final Modification Submission

Instructions for submitting modification:

Note: When updating license details

- If your licensing agency does not allow online verification free of charge, please upload your current license as your business status is at risk of being terminated for expired licenses.
- After you submit the modification, you cannot make further changes until your modification application is approved.
- You must press **SUBMIT MODIFICATION** for your update to be reviewed.

Confirm & Sign

I, the undersigned, certify 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 any 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: 01/30/2024 12:19:51

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/SOVT-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.



Updating Servicing Provider Information (FOR PROVIDERS ENROLLED AS GROUP PROVIDERS)

Note: *If the Provider is enrolled as a Group Provider*, this additional step will appear *before* the **Payment Details** step.

1. Select the **Step 10: Servicing Provider Information** link.

<input type="checkbox"/>	Step 9: EDI Contact Information	Required
<input type="checkbox"/>	Step 10: Servicing Provider Information ← 1	Required
<input type="checkbox"/>	Step 11: Payment Details	Required

2. To add additional servicing providers, select **Add**.

If associating additional servicing providers, within the **Associate Servicing Provider** window, enter the required information and select **OK**.

Close Add Inactivate

Filter By : [] And []

If the group or facility has more than 9 servicing providers, the group/facility itself is responsible for validating the information.

<input type="checkbox"/>	SSN/FEIN ▲▼	Provider Name ▲▼	NPI ▲▼	Provider Type ▲▼
<input type="checkbox"/>	[]	[]	[]	25 - Physician (MD) & Physician (MD)

View Page: 1 Go + Page Count SaveToCSV Viewing Page: 1



Updating Servicing Provider Information (FOR PROVIDERS ENROLLED AS GROUP PROVIDERS)

- To deactivate a servicing provider, select the checkbox next to the **SSN/FEIN** link, select **Inactivate**, then select **OK** on the **Confirmation** window to confirm.

The screenshot shows the 'Servicing Provider List' interface. At the top, there are buttons for 'Close', 'Add', and 'Inactivate'. Below these is a 'Filter By' dropdown menu with a red circle '3' next to it. A red arrow points from this circle to the 'Inactivate' button. Below the filter is a table with columns: 'SSN/FEIN', 'Provider Name', 'NPI', and 'Provider Ty'. The first row has a checkbox in the 'SSN/FEIN' column, a red arrow pointing to it, and the text '25 - Physician (MD) & Physician ('. At the bottom, there are controls for 'View Page: 1', 'Go', '+ Page Count', 'SaveToCSV', and 'Viewing Page: 1'.

- To update the respective servicing provider, select the **SSN/FEIN** links. If making updates to the selected servicing providers, select **Save** and return to the list of steps.

The screenshot shows the 'Servicing Provider List' interface. At the top, there are buttons for 'Close', 'Add', and 'Inactivate'. Below these is a 'Filter By' dropdown menu. A red arrow points from the 'Filter By' dropdown to the 'SSN/FEIN' link in the first row of the table. A red circle '4' is next to the 'SSN/FEIN' link. The text in the table is '25 - Physician (MD) & Physician ('. At the bottom, there are controls for 'View Page: 1', 'Go', '+ Page Count', 'SaveToCSV', and 'Viewing Page: 1'.



Updating Servicing Provider Information (FOR PROVIDERS ENROLLED AS GROUP PROVIDERS)

5. After saving the update, select **Close**.

Note: If this is the only step needing an update, proceed to the last step, **13. Submit Maintenance Request for Review**.

The screenshot shows the 'Servicing Provider List' interface. At the top, there are three buttons: 'Close', 'Add', and 'Inactivate'. A red callout bubble with the number '5' points to the 'Close' button. Below the buttons is a search filter section with 'Filter By:' followed by two dropdown menus and an 'And' connector. Below the filter is a note: 'If the group or facility has more than 9 servicing providers, the group/facility itself is responsible for validation'. Below the note is a table with columns: 'SSN/FEIN', 'Provider Name', 'NPI', and 'Provider Type'. The first row of the table is partially visible, showing '25 - Physician (MD) & Physician ('. At the bottom of the interface, there is a 'View Page: 1' field, a 'Go' button, a '+ Page Count' button, a 'SaveToCSV' button, and 'Viewing Page: 1'.



Changing Profiles

Notes:

- Profiles can be switched at any point while in the Provider Portal by selecting the **Profile** drop-down list from the menu bar near the top of the Provider Portal. A list of available profiles displays.
- By selecting the applicable profile from this drop-down list, the Provider Portal functions you have access to will be updated after making that selection.

