

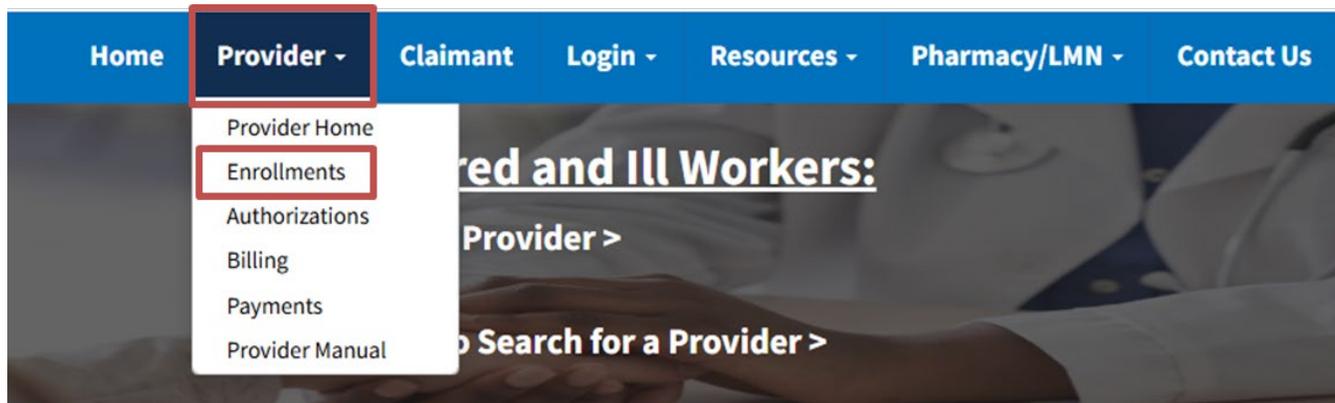


Resubmitting a Returned to Provider Enrollment Application

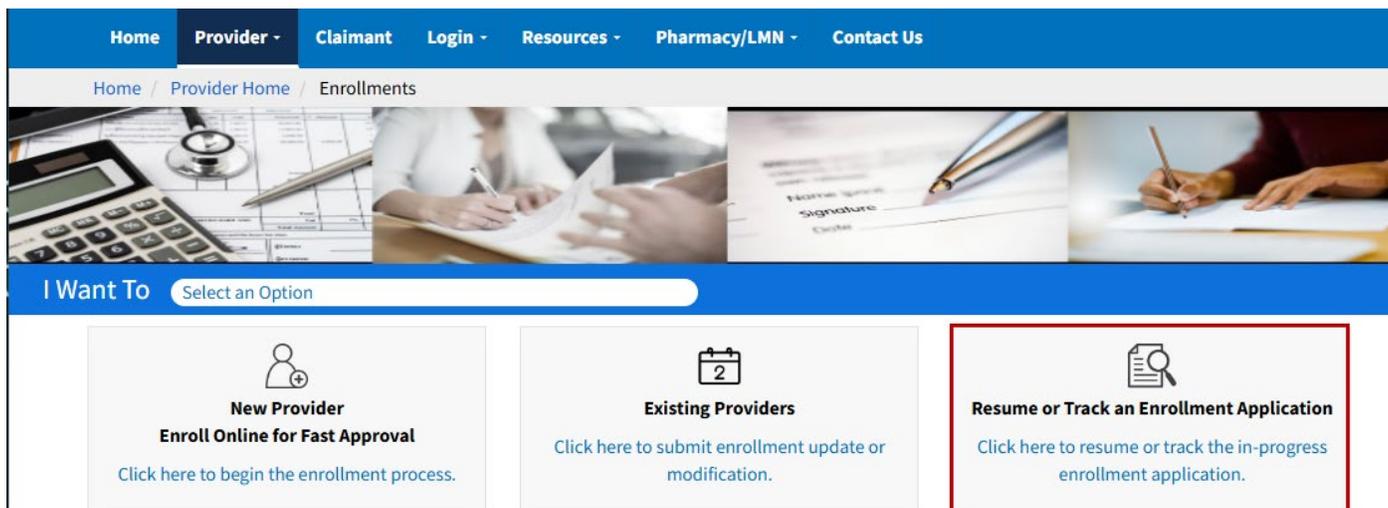
If a provider receives a Return to Provider (RTP) letter after submitting an enrollment application, the provider can make the necessary updates to the initial application and resubmit it. This update cannot be performed through a resubmission of the initial application.

Note: Corrections or updates to the enrollment type require a new application submission.

1. Go to the [Medical Bill Processing Portal homepage \(https://owcpmed.dol.gov\)](https://owcpmed.dol.gov) and select **Enrollments** from the **Provider** drop-down list.



2. Locate the **Resume or Track an Enrollment Application** section and select the **Click here to resume or track the in-progress enrollment application** link.





Resubmitting a Returned to Provider Enrollment Application

3. In the **Existing User** section, enter the email address used during OWCP Connect registration and select **LOGIN**.

The screenshot shows the top navigation bar of the OWCP Connect portal. On the left is the Department of Labor logo and the text "United States Department of Labor Office of Workers' Compensation Programs". On the right is the OWCP logo with the tagline "Protecting Injured Workers Responsibly and Compassionately" and a "Help | FAQ" link.

Below the header are three main sections:

- OWCP Connect:** A list of services available to users, such as "Look up a claimant's case number" and "Submit/resubmit bills and adjustments".
- Existing User:** A login form with a text input field for "Login Using Email Address:", a "LOGIN" button, and links for "Forgot password?" (PASSWORD RESET) and "Change Email?" (CHANGE EMAIL).
- New User:** A "CREATE ACCOUNT" button and "Information for Medical Providers" with a list of links: "1. This process generally takes 3-5 minutes", "2. Enrollment Tutorials (Click Here)", and "3. Contact Us (Click Here)".

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

The screenshot shows the "Login" page. At the top, it says "Welcome [redacted] Please verify your security image and enter password." Below this is a "Security Image" section with a decorative image of a tree and ornaments. Underneath is a "Key Phrase" section with the word "tree" and a "Password *" input field. A red box highlights the "Password *" field and the "SUBMIT" button. A note below the field says "* Required Field".

On the right side, there is an "Instructions" box containing the following text:

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 Provider Enrollment Application

5. Enter the **Application Number** and **social security number (SSN)** or **Federal Employee Identification Number (FEIN)**.
 - If you know the Application Number and SSN or FEIN, Select here for next steps.
 - If you do not know the Application Number, select the **link** after the “Need help finding the application number?” text.

The screenshot shows the eCAMS HCE application tracking interface. At the top, there is a navigation bar with a profile dropdown, 'External Links', 'Help', and 'Logout'. Below the navigation bar is a breadcrumb trail: 'Track Application'. There are 'Close' and 'Submit' buttons. The main content area contains the text: 'Please provide the Application Number and SSN/FEIN to track your application.' Below this is a link: 'Need help finding the application number? Please select this [link](#) to look up and retrieve your application number.' There are two input fields: 'Application Number: *' and 'SSN/FEIN: *'. The 'Application Number' field is highlighted with a red box.

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

Note: The application number is located in the Return to Provider (RTP) letter.

The screenshot shows the eCAMS HCE application number lookup interface. At the top, there is a navigation bar with a profile dropdown, 'External Links', 'Help', and 'Logout'. Below the navigation bar is a breadcrumb trail: 'Track Application > Application Number Lookup'. There are 'Close' and 'Submit' buttons. The main content area contains a form titled 'Application Number Lookup' with three input fields: 'National Provider Identifier: *', 'SSN/FEIN: *', and 'Zip Code: '. The 'National Provider Identifier' and 'SSN/FEIN' fields are highlighted with red boxes. Below the form is a section titled 'Enrollment Applications' with a note: 'Note: Applications that are not yet approved are displayed below.'



Resubmitting a Returned to Provider Enrollment Application

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

The screenshot shows the eCAMS HCEV interface. At the top, there is a navigation bar with 'Profile', 'External Links', 'Help', and 'Logout'. Below this is a breadcrumb trail: 'Track Application > Application Number Lookup'. The main content area contains a form titled 'Application Number Lookup' with two buttons: 'Close' and 'Submit'. The 'Submit' button is highlighted with a red box. Below the buttons are three input fields: 'National Provider Identifier:', 'SSN/FEIN:', and 'Zip Code:'. Each field has a red asterisk to its right, indicating a required field.

The system identifies the matching enrollment application and displays the application's details in the **Enrollment Applications** section.

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

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

The screenshot shows the 'Enrollment Applications' section. A note states: 'Note: Applications that are not yet approved are displayed below.' Below the note is a table with the following columns: 'Application Number', 'Provider Name', 'National Provider Identifier', 'SSN/FEIN', 'Address', 'Status', 'Created Date', and 'Submitted Date'. The first row of the table is highlighted with a red box. The 'Application Number' column header is also highlighted with a red box. Below the table is a pagination control showing 'View Page: 1', 'Go', '+ Page Count', 'Viewing Page: 1', and navigation buttons for 'First', 'Prev', 'Next', and 'Last'. There is also a 'Save To CSV' button.

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



Resubmitting a Returned to Provider Enrollment Application

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

The screenshot shows the eCAMS HCE interface. At the top left is the logo. A dark blue navigation bar contains a profile dropdown, 'External Links', 'Help', and 'Logout'. Below this is a breadcrumb trail: 'Home > Track Application'. Two buttons, 'Close' and 'Submit', are visible. The main content area contains the instruction: 'Please provide the Application Number and SSN/FEIN to track your application.' Below this is a link: 'Need help finding the application number? Please select this link to look up and retrieve your application number.' There are two input fields: 'Application Number:' and 'SSN/FEIN:'. The 'Application Number' field is highlighted with a red border.

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

This screenshot is identical to the one above, showing the same eCAMS HCE interface. However, in this instance, the 'SSN/FEIN' input field is highlighted with a red border.



Resubmitting a Returned to Provider Enrollment Application

11. To return to the application and make the necessary adjustments as indicated in the RTP letter, select **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 display as **Incomplete**.

- Each required step must be opened to verify that the information is correct or to make necessary revisions.
- Selecting the up and down arrows within the **Required** column sorts each step by “Required” or “Optional.”
- You must open each step, verify or adjust the information as needed, and close the step.
- The step **Status** will then be marked as “Complete.”

Close Required Credentials Delete

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	03/14/2025	03/14/2025	Complete	
Step 2: Add Location	Required			Incomplete	
Step 3: Add Taxonomies	Required			Incomplete	
Step 4: Add Ownership Details	Optional			Incomplete	
Step 5: Add Professional Licenses and Certifications	Required			Incomplete	
Step 6: Add Identifiers	Optional			Incomplete	
Step 7: Add EDI Submission Method	Optional			Incomplete	
Step 8: Add EDI Submitter Details	Optional			Incomplete	
Step 9: Add EDI Contact Information	Optional			Incomplete	
Step 10: Add Payment Details	Required			Incomplete	
Step 11: Complete Provider Disclosure	Required			Incomplete	
Step 12: View/Upload Attachments	Optional			Incomplete	
Step 13: Submit Enrollment Application for Review	Required			Incomplete	



Resubmitting a Returned to Provider Enrollment Application

Note: After verifying, revising, or adding the required information for each step, submit the enrollment application as follows.

12. Select the **Step 13: Submit Enrollment Application for Review** link.

Application Number: [redacted] Name: Test Enrollment Type: Individual

Close Required Credentials Delete

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	03/14/2025	03/14/2025	Complete	
Step 2: Add Location	Required			Incomplete	
Step 3: Add Taxonomies	Required			Incomplete	
Step 4: Add Ownership Details	Optional			Incomplete	
Step 5: Add Professional Licenses and Certifications	Required			Incomplete	
Step 6: Add Identifiers	Optional			Incomplete	
Step 7: Add EDI Submission Method	Optional			Incomplete	
Step 8: Add EDI Submitter Details	Optional			Incomplete	
Step 9: Add EDI Contact Information	Optional			Incomplete	
Step 10: Add Payment Details	Required			Incomplete	
Step 11: Complete Provider Disclosure	Required			Incomplete	
Step 12: View/Upload Attachments	Optional			Incomplete	
Step 13: Submit Enrollment Application for Review	Required			Incomplete	

View Page: 1 Go Page Count SaveToCSV Viewing Page: 1 << First < Prev > Next >> Last

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

Track Application > Individual Enrollment > Submit Enrollment

Application Number: [redacted] Name: [redacted] 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: [input] * Last Name: [input] *

Title: [input] Signature Date: 07/30/2024 12:26:07



Resubmitting a Returned to Provider Enrollment Application

14. Optionally, in the **Title** field, enter 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. The application will go into a submitted status. Once the application completes the IRS validation, the status will change 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