

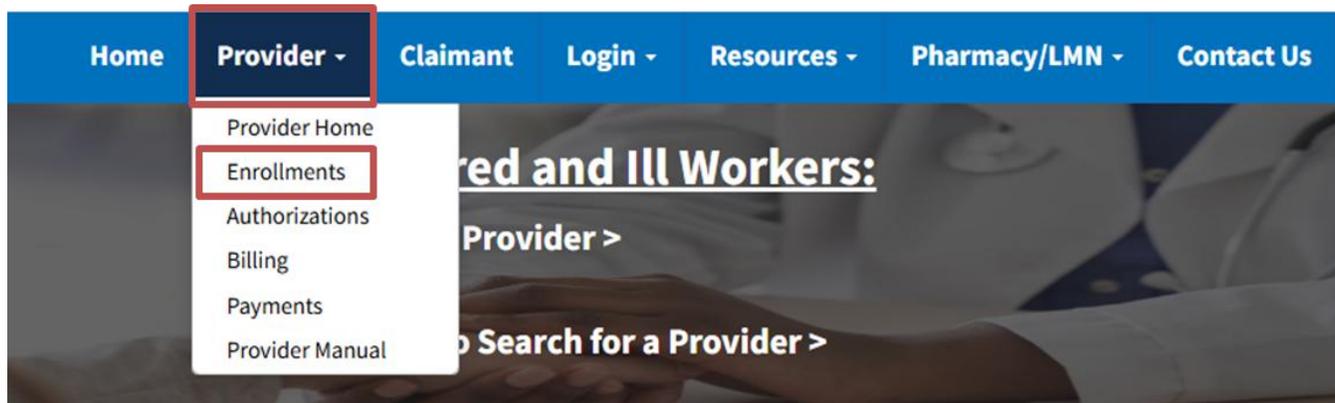


Resubmitting a Returned to Provider Enrollment Application

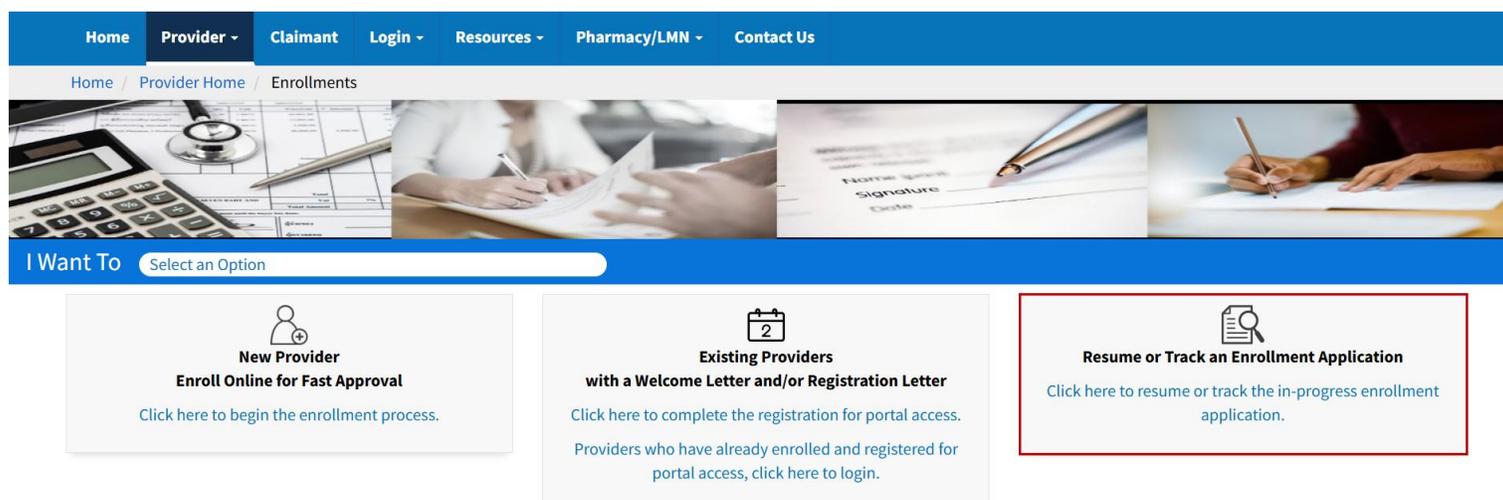
If a provider receives a Return to Provider (RTP) letter after submitting an enrollment application, the provider can make the necessary updates to the initial application and resubmit it.

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.





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

The screenshot shows the top navigation bar of the OWCP Connect portal. On the left is the United States 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 including looking up claimant case numbers, finding diagnosis codes, checking eligibility, submitting authorization requests, and submitting bills.
- Existing User:** A login form with a "Login Using Email Address:" field, 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: "This process generally takes 3-5 minutes", "Enrollment Tutorials (Click Here)", and "Contact Us (Click Here)".

4. Enter the password, then answer the security question and confirm the security image and 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 *" field. A red box highlights the "Password *" field and the "SUBMIT" button. To the right is an "Instructions" sidebar with password criteria: "Passwords must be at least 8 characters long, composed of characters from the each of the following four categories: Uppercase letters, Lowercase letters, Special Characters, and Numbers." It also notes that passwords cannot contain the text of User ID, first name, last name or street address.



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5. Complete the **Track Application** section as applicable:
 - a. If the provider knows the application number and Social Security Number (SSN) or Federal Employee Identification Number (FEIN), proceed to Step 9 for next steps.
 - b. If the provider does not know the application number, select the link in the “Need help...” text just above the **Application Number** field.

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

The screenshot shows the 'Track Existing Application' form in the eCAMS HCEV system. The form includes a 'Close' button and a 'Submit' button. The main heading is 'Track Existing Application'. Below the heading, there is a text prompt: 'Please provide the Application Number and SSN/FEIN to track your application.' This is followed by 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:', both marked with an asterisk to indicate they are required fields.

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

The screenshot shows the 'Application Number Lookup' form in the eCAMS HCEV system. The form includes a 'Close' button and a 'Submit' button. The main heading is 'Application Number Lookup'. Below the heading, there are three input fields: 'National Provider Identifier:', 'SSN/FEIN:', and 'Zip Code:'. The 'National Provider Identifier' and 'SSN/FEIN' fields are highlighted with red boxes and marked with an asterisk to indicate they are required fields. Below the form, there is a section titled 'Enrollment Applications' and a note: 'Note: Applications that are not yet approved are displayed below.'



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

The screenshot shows the eCAMS HCE 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 has a 'Close' button and a 'Submit' button, with the 'Submit' button highlighted by a red box. Below the buttons is a form titled 'Application Number Lookup' with three input fields: 'National Provider Identifier:', 'SSN/FEIN:', and 'Zip Code:'. Each field has an asterisk to its right, indicating it is required.

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 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 data is highlighted with a red box around the 'Application Number' cell. The status of this application is 'Pending Submission' and the created date is '03/14/2025'.

Application Number	Provider Name	National Provider Identifier	SSN/FEIN	Address	Status	Created Date	Submitted Date
[Redacted]					Pending Submission	03/14/2025	



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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 application tracking interface. At the top left is the eCAMS HCE logo. Below it is a navigation bar with a home icon, a user profile icon, and a dropdown menu labeled 'Profile:'. To the right of the profile menu are links for 'External Links', 'Help', and 'Logout'. Below the navigation bar is a breadcrumb trail: 'Home > Track Application'. Below the breadcrumb trail are two buttons: 'Close' and 'Submit'. Below the buttons is a message: 'Please provide the Application Number and SSN/FEIN to track your application.' Below the message is a link: 'Need help finding the application number? Please select this link to look up and retrieve your application number.' Below the link are two input fields: 'Application Number:' and 'SSN/FEIN:'. The 'Application Number' field is highlighted with a red box.

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

The screenshot shows the eCAMS HCE application tracking interface. At the top left is the eCAMS HCE logo. Below it is a navigation bar with a home icon, a user profile icon, and a dropdown menu labeled 'Profile:'. To the right of the profile menu are links for 'External Links', 'Help', and 'Logout'. Below the navigation bar is a breadcrumb trail: 'Home > Track Application'. Below the breadcrumb trail are two buttons: 'Close' and 'Submit'. Below the buttons is a message: 'Please provide the Application Number and SSN/FEIN to track your application.' Below the message is a link: 'Need help finding the application number? Please select this link to look up and retrieve your application number.' Below the link are two input fields: 'Application Number:' and 'SSN/FEIN:'. The 'SSN/FEIN' field is highlighted with a red box.



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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: *

- The enrollment application will display the status of all required steps as “Incomplete.”
- Providers must open each required step to verify that the information is correct or to make necessary revisions. The step **Status** will then be marked as “Complete.”
- Providers can select the column header in the **Required** column to sort each step by “Required” or “Optional.”

Provider data is pre-populated from the PECOS System. Please review and update as required before enrollment application submission.

After completing and verifying all required steps, select **Submit Enrollment Application for Review** to submit your enrollment application.

Enroll Provider -Individual

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

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12. After verifying, revising, or adding the required information for each step, select **Step 13: Submit Enrollment Application for Review** to submit the enrollment application.

Close Required Credentials Delete

Provider data is pre-populated from the PECOS System. Please review and update as required before enrollment application submission.

After completing and verifying all required steps, select Submit Enrollment Application for Review to submit your enrollment application.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/26/2025	11/26/2025	Complete	
Step 2: Add Location	Required			Incomplete	
Step 3: Add Taxonomies	Required			Incomplete	
Step 4: Add Professional Licenses and Certifications	Required			Incomplete	
Step 5: Add Payment Details	Required			Incomplete	
Step 6: Complete Provider Disclosure	Required			Incomplete	
Step 7: View/Upload Attachments	Required			Incomplete	
Step 8: Add Identifiers	Optional			Incomplete	
Step 9: Add EDI Submission Method	Required			Incomplete	
Step 10: Add EDI Submitter Details	Required			Incomplete	
Step 11: Add EDI Contact Information	Required			Incomplete	
Step 12: Add Ownership Details	Optional			Incomplete	
Step 13: Submit Enrollment Application for Review	Required			Incomplete	

View Page: 1 Page Count Save To CSV 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: 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. If applicable enter the title of the final submitter in the **Title** field.

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.

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First Name: [] * Last Name: [] *

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

15. Select **Submit Enrollment**. 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.

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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