

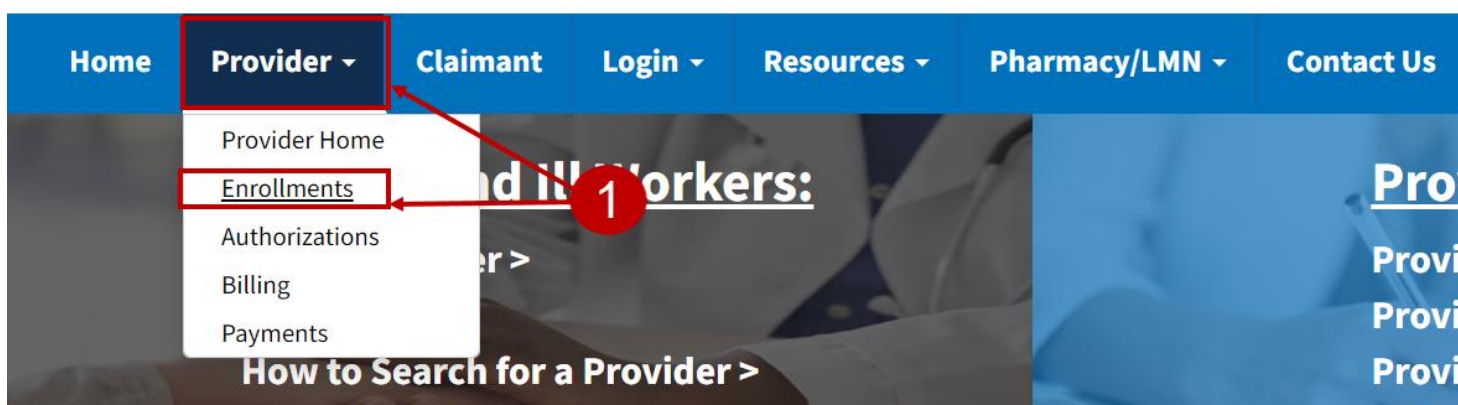


### Resubmitting a Returned to Provider Enrollment Application

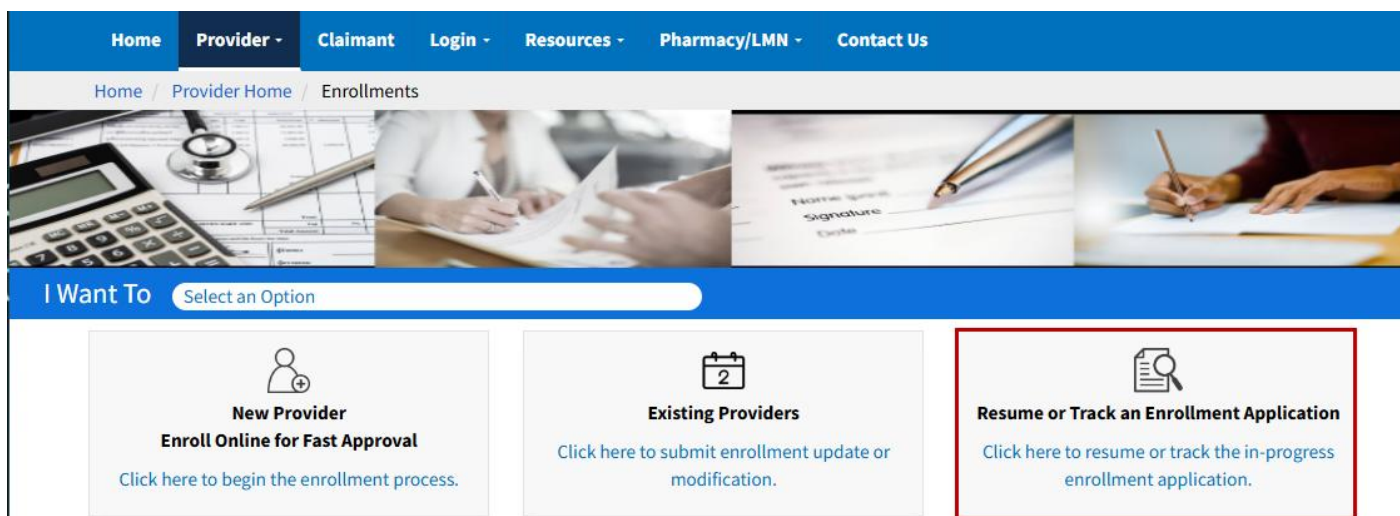
If a provider receives a Return to Provider (RTP) letter after submitting an enrollment application, the provider can make required updates to the initial application and resubmit it.

If a provider receives an RTP letter, complete the following steps:

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



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





### Resubmitting a Returned to Provider Enrollment Application

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

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



### Resubmitting a Returned to Enrollment Application

5. In the **Application Number** field, enter the application number received 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 profile dropdown, and links for External Links, Help, and Logout. The main heading is "Track Application". Below this are "Close" and "Submit" buttons. A message reads: "Please provide the Application Number and SSN/FEIN to track your application." There are two input fields: "Application Number:" and "SSN/FEIN:". The "Application Number:" field is highlighted with a red box.

6. 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 previous one, showing the eCAMS HCE application tracking interface. The "SSN/FEIN:" field is now highlighted with a red box, indicating the step where the user should enter their Social Security Number or Federal Employer Identification Number.



## Resubmitting a Returned to Provider Enrollment Application

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

🏠 > [Track Application](#)

---

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

Application Number: \*

SSN/FEIN: \*

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

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

View/Update Provider Data - Facility/Agency/Organization/Institution

Business Process Wizard - Provider Data Modification (Facility/Agency/Organization/Institution). In order to finalize submission of your requested changes, you must complete the Step - Submit Maintenance Request for Review.

<input type="checkbox"/>	Step ▲▼	Required ▲▼	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/>	Step 1: Basic Information	Required	03/30/2023	05/23/2022	Complete	Updated	
<input type="checkbox"/>	Step 2: Location	Required	08/31/2022	08/31/2022	Complete		
<input type="checkbox"/>	Step 3: Taxonomies	Required	11/08/2021	01/13/2022	Complete		
<input type="checkbox"/>	Step 4: Ownership Details	Optional			Complete		
<input type="checkbox"/>	Step 5: Business Licenses and Certifications	Required	06/02/2022	07/12/2022	Complete		
<input type="checkbox"/>	Step 6: Identifiers	Required	05/16/2022	05/23/2022	Complete		
<input type="checkbox"/>	Step 7: EDI Submission Method	Optional	03/29/2024		Complete	Updated	
<input type="checkbox"/>	Step 8: EDI Submitter Details	Required	03/29/2024		Complete	Updated	
<input type="checkbox"/>	Step 9: EDI Contact Information	Required	11/08/2021	01/13/2022	Complete		
<input type="checkbox"/>	Step 10: Payment Details	Required	01/06/2022	01/13/2022	Complete		
<input type="checkbox"/>	Step 11: Complete Provider Disclosure	Required	11/08/2021	01/13/2022	Complete		
<input type="checkbox"/>	Step 12: View/Upload Attachments	Optional	06/02/2022	07/12/2022	Complete		
<input type="checkbox"/>	Step 13: Submit Maintenance Request for Review	Required			Incomplete		



### Resubmitting a Returned to Provider Enrollment Application

**Note:** After verifying the data in each step and revising or adding the required information, submit the enrollment application.

#### 8. Select **Step 13: Submit Enrollment Application for Review.**

Business Process Wizard - Provider Data Modification (Facility/Agency/Organization/Institution). In order to finalize submission of your requested changes, you must complete the Step - Submit Maintenance Request for Review.

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
Step 1: Basic Information	Required	03/30/2023	05/23/2022	Complete	Updated	
Step 2: Location	Required	08/31/2022	08/31/2022	Complete		
Step 3: Taxonomies	Required	11/08/2021	01/13/2022	Complete		
Step 4: Ownership Details	Optional			Complete		
Step 5: Business Licenses and Certifications	Required	06/02/2022	07/12/2022	Complete		
Step 6: Identifiers	Required	05/16/2022	05/23/2022	Complete		
Step 7: EDI Submission Method	Optional	03/29/2024		Complete	Updated	
Step 8: EDI Submitter Details	Required	03/29/2024		Complete	Updated	
Step 9: EDI Contact Information	Required	11/08/2021	01/13/2022	Complete		
Step 10: Payment Details	Required	01/06/2022	01/13/2022	Complete		
Step 11: Complete Provider Disclosure	Required	11/08/2021	01/13/2022	Complete		
Step 12: View/Upload Attachments	Optional	06/02/2022	07/12/2022	Complete		
Step 13: Submit Maintenance Request for Review	Required			Incomplete		

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

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 & 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: 11/04/2024 13:13:23





### Resubmitting a Returned to Provider Enrollment Application

10. *Optionally*, in the **Title** field, enter the title of the final submitter.

Provider Portal > FAOI Modification > Submit Provider Modification

OWCP ID/NPI: [ ] Name: GRADY MEMORIAL HOSPITAL Enrollment Type: Facility/Agency/Organization/Institution

Close Submit Modification

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 & 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: 11/04/2024 13:13:23

Privacy Act Statement

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

Provider Portal > FAOI Modification > Submit Provider Modification

OWCP ID/NPI: [ ] Name: GRADY MEMORIAL HOSPITAL Enrollment Type: Facility/Agency/Organization/Institution

Close **Submit Modification**

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 & 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: 11/04/2024 13:13:23

Privacy Act Statement