



## Updating Provider Information QRG Content:

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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

**eCAMS<sup>TM</sup>**  
**HCE**

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

Available Provider IDs: 020211301

Go

2. Select **Go**.

Welcome to the WCMBP Provider Portal

**eCAMS<sup>TM</sup>**  
**HCE**

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

Available Provider IDs: 020211301

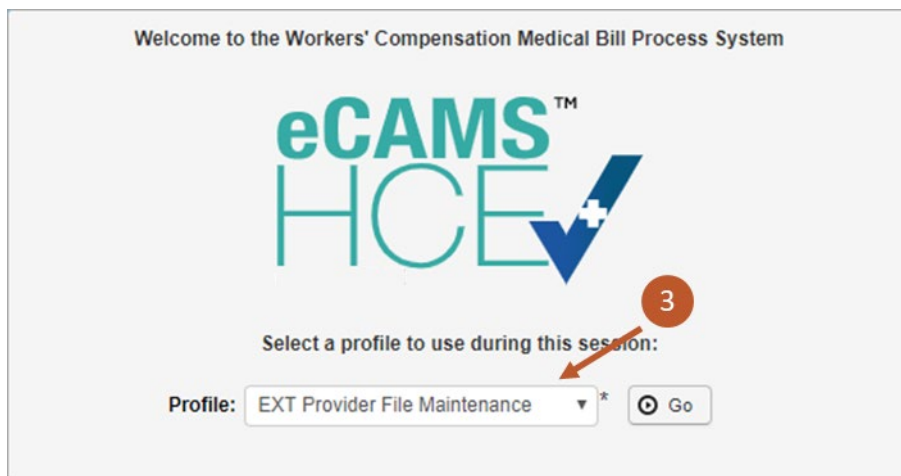
Go



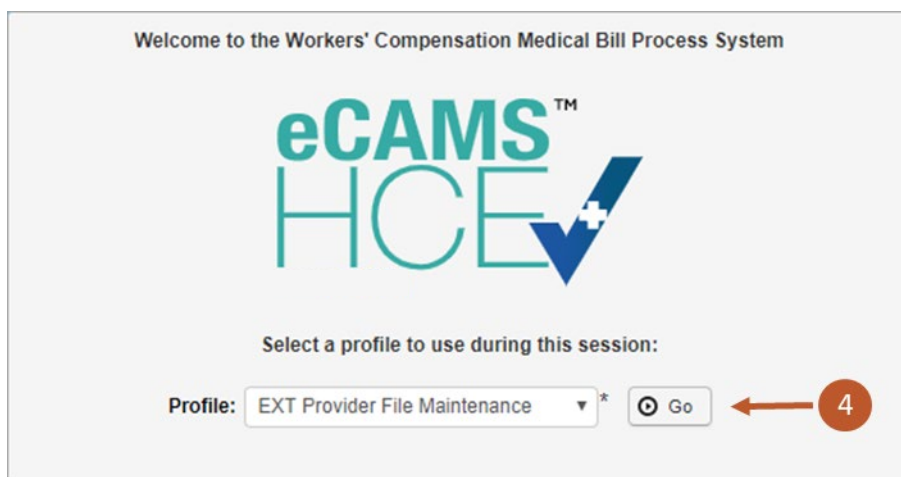
## Selecting Provider ID and Profile

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.



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





## 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 
<b>Maintain Provider Information</b>
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"/>	<b>Step 1: Basic Information</b> ← 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**) in the provider portal, that is a required step to submit the 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"/>	<a href="#">Step 1: Basic Information</a>	Required
<input type="checkbox"/>	<a href="#">Step 2: Location</a> ← 1	Required
<input type="checkbox"/>	<a href="#">Step 3: Taxonomies</a>	Optional
<input type="checkbox"/>	<a href="#">Step 4: Ownership Details</a>	Optional
<input type="checkbox"/>	<a href="#">Step 5: Licenses and Certifications</a>	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"/>	Location Name	Location Details	01/01/1964	12/31/2999	Approved	Active



## Updating Location

3. Review the **Location Details** section. Update fields, if applicable.

Close Save

Location Details **3**

Business Name: \*

Contact Last Name: \* Contact First Name: \*

Phone Number: \* Fax Number:

Email Address:

I wish to opt-in for paperless correspondence.  
By selecting this option, correspondence will only be available via Medical Bill Processing Portal and will not be mailed, except for IRS letters and provider enrollment status correspondence.  
Note: OWCP is not responsible for undelivered correspondence notification emails due to invalid or outdated email address.

System Status: Approved Location Start Date: 01/01/1964 Location End Date: 12/31/2999  
Business Status: Active Business Status Start Date: 01/01/1964 Business Status End Date: 12/31/2999

4. To change the 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="checkbox"/>	Physical	



## Updating Location (Optional)

- To opt-in for paperless correspondences, check the provided checkbox. Once selected, the Email Address field becomes mandatory.

Close Save

Location Details

Business Name: \*

Contact Last Name: \* Contact First Name: \*

Phone Number: \* Fax Number:

Email Address:

**5**  I wish to opt-in for paperless correspondence.  
By selecting this option, correspondence will only be available via Medical Bill Processing Portal and will not be mailed, except for IRS letters and provider enrollment status correspondence.  
Note: OWCP is not responsible for undelivered correspondence notification emails due to invalid or outdated email address.

System Status: Approved Location Start Date: 01/01/1964 Location End Date: 12/31/2999  
Business Status: Active Business Status Start Date: 01/01/1964 Business Status End Date: 12/31/2999

- If the opt-in for paperless correspondence checkbox is selected this field becomes mandatory, enter the applicable **Email Address**.  
**Note:** if you select **NEXT** without adding an email address, the system will show an error message: "An Email address is required if you opt-in for paperless correspondence; please enter an Email Address."

Close Save

Location Details

Business Name: \*

Contact Last Name: \* Contact First Name: \*

Phone Number: \* Fax Number:

**6** Email Address: \*

I wish to opt-in for paperless correspondence.  
By selecting this option, correspondence will only be available via Medical Bill Processing Portal and will not be mailed, except for IRS letters and provider enrollment status correspondence.  
Note: OWCP is not responsible for undelivered correspondence notification emails due to invalid or outdated email address.

System Status: Approved Location Start Date: 01/01/1964 Location End Date: 12/31/2999  
Business Status: Active Business Status Start Date: 01/01/1964 Business Status End Date: 12/31/2999





## Updating Location

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

**Location Address**

Type of Address: Physical Address

Address Input Option:  Manually Input

End Date: 12/31/2999

Address Line 1:  \* Address Line 2:

Address Line 3:

City/Town:  \*

State/Province:  \* County:  \*

Country: United States \* Zip Code:  -  **+ Address**

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

**Address details**

Address Line 1:  \* Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:  **8**

City/Town:  \*

State/Province:  \*

County:  \*

Country:  \*

Zip Code:  -  **+ Validate Address**



## Updating Location

9. 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, and Country, all marked with an asterisk. The Zip Code field is highlighted with a red circle containing the number 9 and an arrow pointing to it. A '+ Validate Address' button is located to the right of the Zip Code field.

10. Select **+ Validate Address**.

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

This screenshot is identical to the previous one, but the red circle and arrow now point to the '+ Validate Address' button, indicating step 10 of the process.



## Updating Location

11. 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 a status message "Address validation successful". The form contains several input fields: "Address Line 1" (with a subtext "(Enter Street Address or PO Box Only)"), "Address Line 2", "Address Line 3", "City/Town", "State/Province", "County" (set to "York"), "Country" (set to "United States"), and "Zip Code". A "Validate Address" button is located below the zip code field. At the bottom right, there are "OK" and "Cancel" buttons. A red circle with the number "11" and a red arrow points to the "OK" button.

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

The screenshot shows a form titled "Location Address" with a sub-section "Type of Address: Mailing". Below this, there is a "Start Date" field with a calendar icon. At the top of the form, there is an "OWCP ID/NPI" field. Below the "OWCP ID/NPI" field, there are "Close" and "Save" buttons. A red circle with the number "12" and a red arrow points to the "Save" button.



## Updating Location

13. 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.

Close Save

Location Details

13

Business Name:

Contact Last Name:

Phone Number:

Email Address:

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

**Note:** If this is the only step needing an update, proceed to the last step (**13. Submit Maintenance Request for Review**) in the provider portal, that is a required step to submit the maintenance request for review.

Close 14

Provider Locations

Filter By :  And

<input type="checkbox"/>	Location Name ▲▼	
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

View Page: 1 Go + Page Count Save To CSV



## Updating Taxonomies

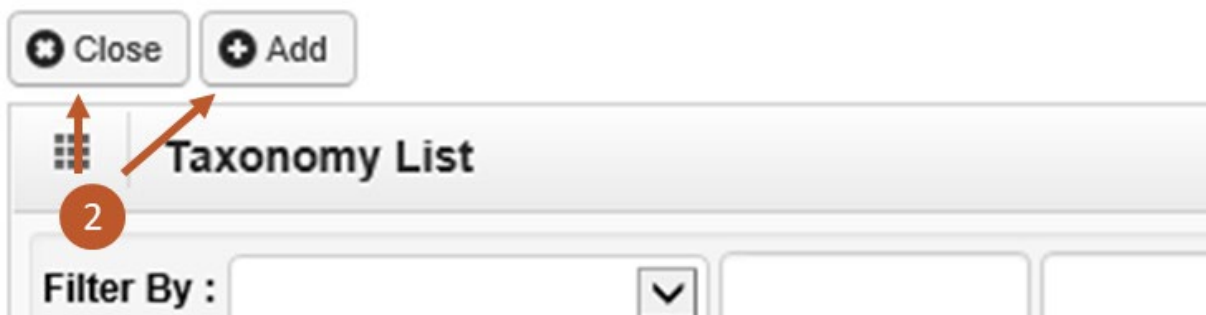
1. Select the **Step 3: Taxonomies** link.

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

<input type="checkbox"/>	Step	Required	Last
<input type="checkbox"/>	<a href="#">Step 1: Basic Information</a>	Required	05/0
<input type="checkbox"/>	<a href="#">Step 2: Location</a>	Required	05/0
<input type="checkbox"/>	<a href="#">Step 3: Taxonomies</a> ← 1	Required	
<input type="checkbox"/>	<a href="#">Step 4: Ownership Details</a>	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**) in the provider portal, that is a required step to submit the maintenance request for review.





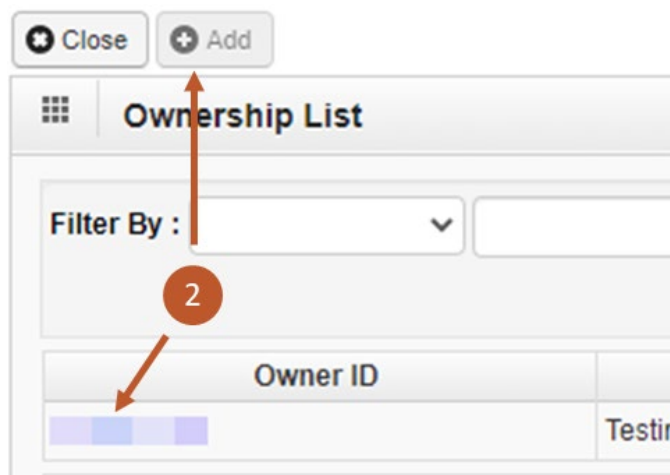
## Updating Ownership Details

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

<input type="checkbox"/>	Step	Required	Last
<input type="checkbox"/>	<a href="#">Step 1: Basic Information</a>	Required	05/0
<input type="checkbox"/>	<a href="#">Step 2: Location</a>	Required	05/0
<input type="checkbox"/>	<a href="#">Step 3: Taxonomies</a>	Required	
<input type="checkbox"/>	<a href="#">Step 4: Ownership Details</a>	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**) in the provider portal, that is a required step to submit the 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
<a href="#">Step 1: Provider Basic Information</a>	Required
<a href="#">Step 2: Add Location</a>	Required
<a href="#">Step 3: Add Taxonomies</a>	Required
<a href="#">Step 4: Add Ownership Details</a>	Optional
<a href="#">Step 5: Add Professional Licenses and Certifications</a>	Required
<a href="#">Step 6: Add Identifiers</a>	Optional
<a href="#">Step 7: Add EDI Submission Method</a>	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
<a href="#">License</a>				05/18/1984	05/12/2020	APPROVED	Active	
<a href="#">Certification</a>				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:**  \* **License/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 left, there are 'Close' and 'Add' buttons. Below them is a filter section with 'Filter By' dropdowns, an 'And' operator, and an 'And Operational Status' dropdown set to 'Active'. There are also 'Clear Filter', 'Save Filter', and 'My Filters' buttons. The main table has the following columns: 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 needing an update, proceed to the last step (**13. Submit Maintenance Request for Review**) in the provider portal, that is a required step to submit the maintenance request for review.

The screenshot shows the 'License/Certification List' interface, similar to the previous one. A red circle with the number '7' and an arrow points to the 'Close' button at the top left of the window.

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	



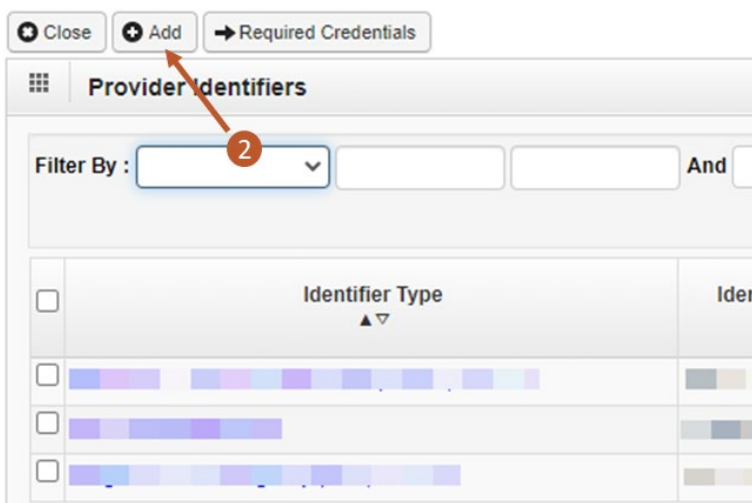
## Updating Identifiers

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	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**.

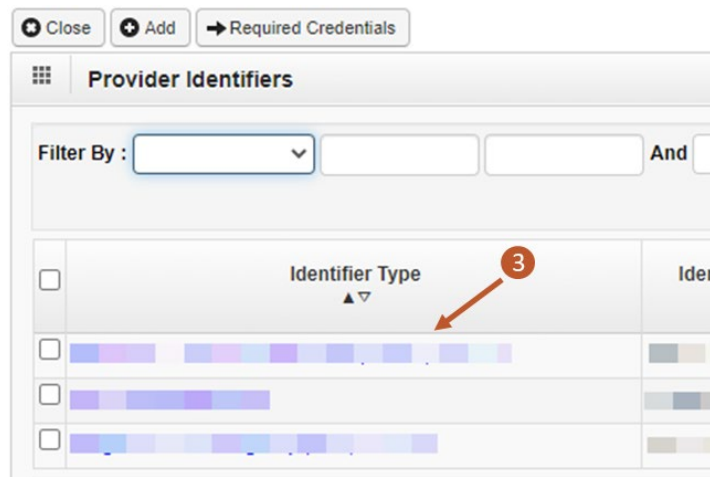




## Updating Identifiers

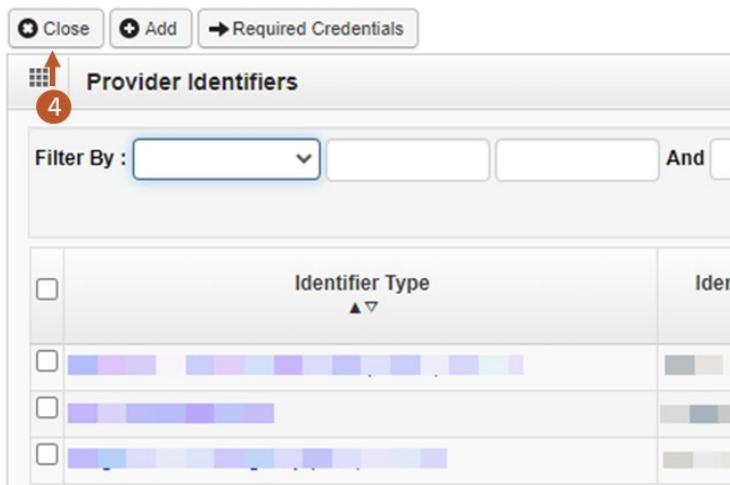
3. To update the respective identifier, select the **Identifier Type** link.

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



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**) in the provider portal, that is a required step to submit the maintenance request for review.





## Updating EDI Submission Method

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

<input type="checkbox"/>	<a href="#">Step 7: EDI Submission Method</a> ← 1	Optional
<input type="checkbox"/>	<a href="#">Step 8: EDI Submitter Details</a>	Required
<input type="checkbox"/>	<a href="#">Step 9: EDI Contact Information</a>	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' with a grid icon. A 'Filter By' section contains two dropdown menus and an 'And' connector. 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**) in the provider portal, that is a required step to submit the maintenance request for review.

The screenshot shows the same web interface as the previous one. At the top, there are 'Close' and 'Add' buttons. A red circle with the number 4 points to the 'Close' button. Below them is a header 'EDI Submission Method' with a grid icon. A 'Filter By' section contains two dropdown menus and an 'And' connector. The main content area is a table with two rows. The first row is 'EDI Submission Method' with a dropdown arrow. The second row is 'Web Batch, Billing Agent/Clearinghouse, FTP Secured Batch, Web Interactive' with a blue link and a checkbox.



## 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"/>	<a href="#">Step 7: EDI Submission Method</a>	Optional
<input type="checkbox"/>	<a href="#">Step 8: EDI Submitter Details</a> ← 1	Required
<input type="checkbox"/>	<a href="#">Step 9: EDI Contact Information</a>	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**) in the provider portal, that is a required step to submit the maintenance request for review.

Close Add ← 2

Billing Agent/Clearinghouse/Submitter List

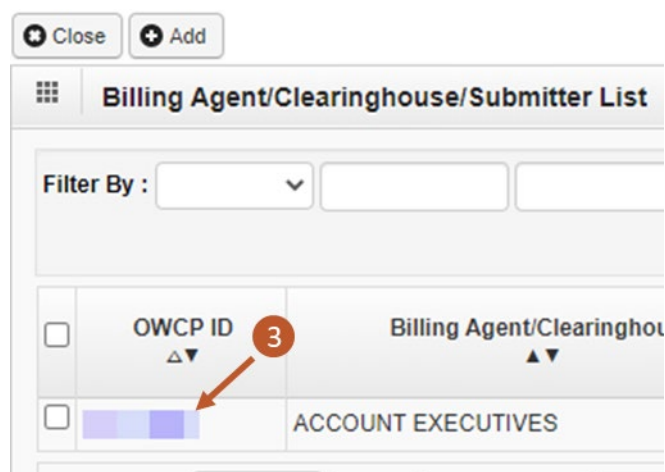
Filter By : [dropdown] [input] [input]

<input type="checkbox"/>	OWCP ID ▲▼	Billing Agent/Clearinghou ▲▼
<input type="checkbox"/>	[blue bar]	ACCOUNT EXECUTIVES



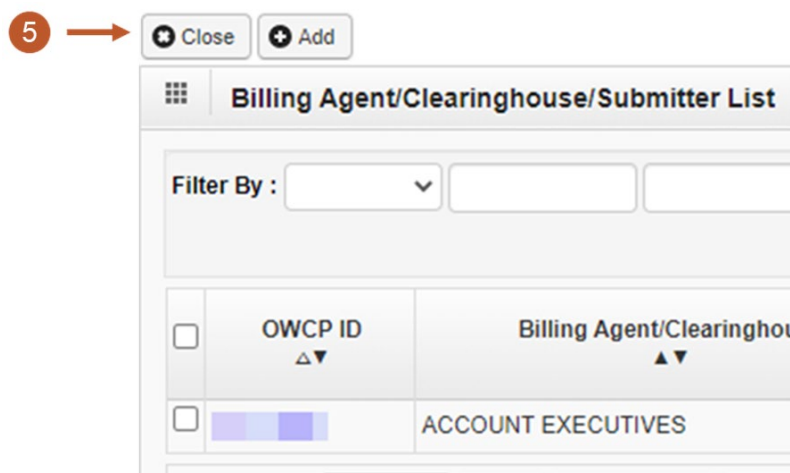
## Updating EDI Submitter Details

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**) in the provider portal, that is a required step to submit the 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"/>	<a href="#">Step 7: EDI Submission Method</a>	Optional
<input type="checkbox"/>	<a href="#">Step 8: EDI Submitter Details</a>	Required
<input type="checkbox"/>	<a href="#">Step 9: EDI Contact Information</a> ← 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"/>	[highlighted]	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**) in the provider portal, that is a required step to submit the maintenance request for review.

Close Add

EDI Contact Information List

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

<input type="checkbox"/>	Contact Title ▲▼	Contact Name ▲▼
<input type="checkbox"/>	[highlighted]	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"/>	<a href="#">Step 10: Payment Details</a> ← 1	Required	
<input type="checkbox"/>	<a href="#">Step 11: Complete Provider Disclosure</a>	Required	
<input type="checkbox"/>	<a href="#">Step 12: View/Upload Attachments</a>	Optional	
<input type="checkbox"/>	<a href="#">Step 13: Submit Maintenance Request for Review</a>	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**.

Close Add ← 2

Payment Details

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

<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 'Payment Details' form with a 'Filter By' dropdown and two input fields. Below is a table with columns 'Account Number' and 'Account Type'. The 'Account Number' column has a dropdown arrow. The first row shows '\*\*\*\*2139' with a red arrow pointing to it and a red circle containing the number '3'. The 'Account Type' column shows 'Checking'.

Account Number	Account Type
****2139	Checking

- 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**) in the provider portal, that is a required step to submit the maintenance request for review.

The screenshot shows the same 'Payment Details' form as above. A red arrow points to the 'Close' button at the top left of the form, with a red circle containing the number '4' next to it.



## Completing Provider Disclosure

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

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



### Completing Provider Disclosure

3. Select **Save**.

The screenshot shows the 'Provider Disclosure' form. At the top left, there are 'Close' and 'Save' buttons. An orange arrow points from a red circle containing the number '3' to the 'Save' button. 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. Each row has a 'Question' column, an 'Answer' column with a dropdown menu set to 'No', and a 'Comments' column with a text input field.

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 'Close' and 'Save' buttons. An orange arrow points from a red circle containing the number '4' to the 'Close' button. The rest of the form, including the table of questions, is identical to the previous screenshot.

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

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

Close Upload Attachments → Required Credentials

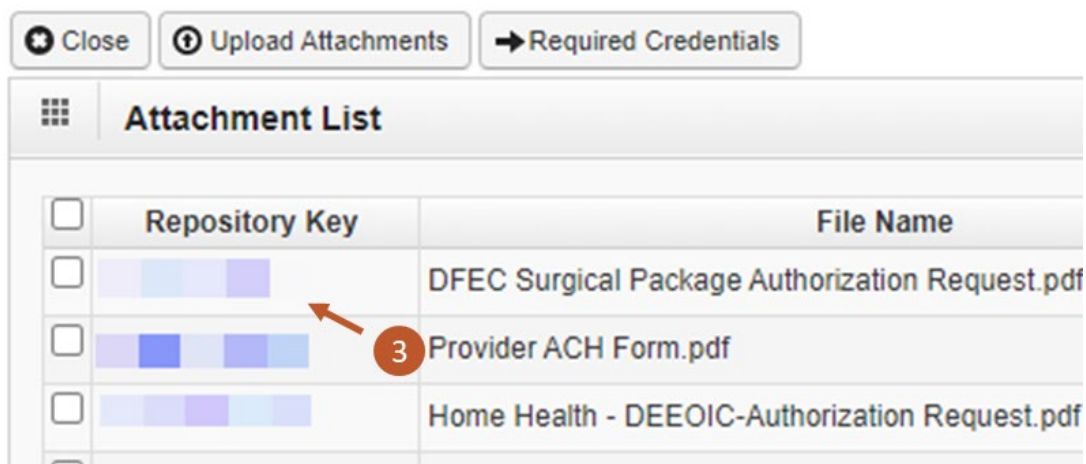
Attachment List 2

<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

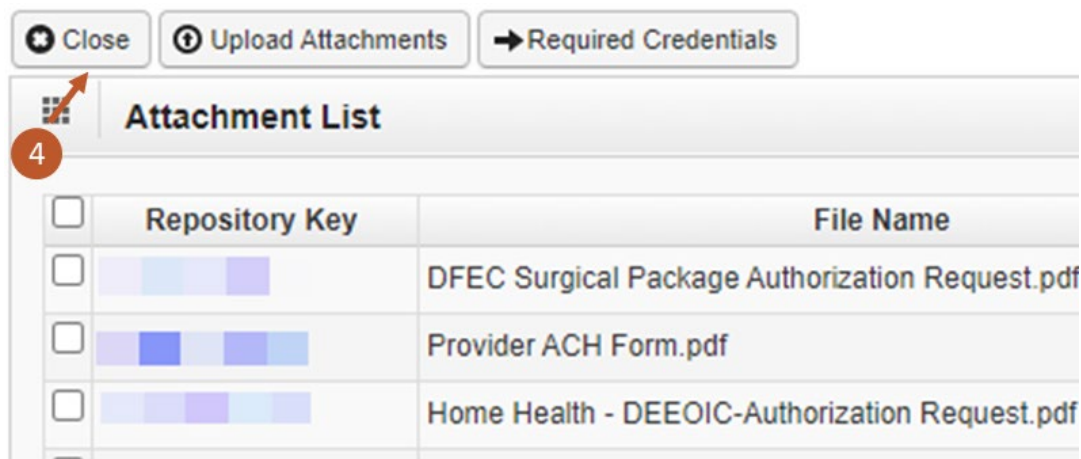


## Viewing and Uploading Attachments

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



- Select **Close**.







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



### Submitting 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.

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.

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.



### Submitting 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 modal window is displayed with the following text:

sit.wcmbp.com says  
The modification request has been submitted for review. Please check this Web site to verify the status of your request.

An 'OK' button is visible in the modal, highlighted with a red circle and the number '5'.

The background page contains the following information:

- Navigation: Provider Portal > FAOI Modification > Submit Provider Modification
- Buttons: Close, Submit Modification
- Section: 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 section with a long paragraph of terms and conditions.
- Form fields: First Name, Last Name, Title, Signature Date (01/30/2024 12:19:51)
- Privacy Act Statement at the bottom.



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

Servicing Provider List

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

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

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

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 section with a 'Filter By' dropdown menu, which is highlighted with a red circle and the number '3'. Below the filter is a table with columns: 'SSN/FEIN', 'Provider Name', 'NPI', and 'Provider Ty'. The first row of the table has a checkbox in the 'SSN/FEIN' column, which is highlighted with a red circle and the number '3'. Below the table are buttons 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 section with a 'Filter By' dropdown menu. Below the filter is a table with columns: 'SSN/FEIN', 'Provider Name', 'NPI', and 'Provider Ty'. The first row of the table has a checkbox in the 'SSN/FEIN' column, which is highlighted with a red circle and the number '4'. Below the table are buttons 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 (**14. Submit Maintenance Request for Review**) in the provider portal, that is a required step to submit the 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. A note below the filter states: '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 pagination section with 'View Page: 1', 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.

