

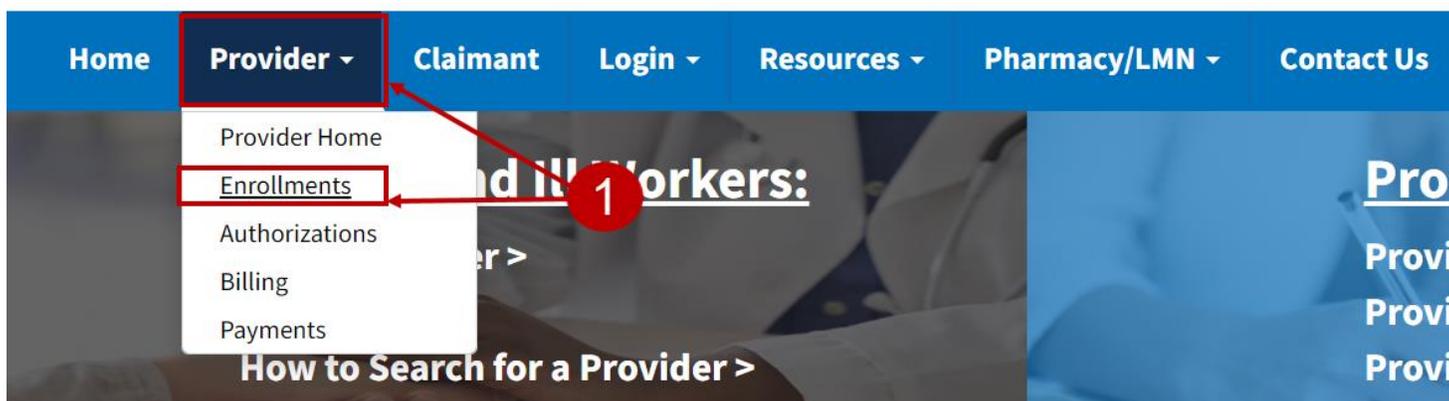


Resubmitting To Provider Enrollment Application

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

If an RTP letter is received, 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.





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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**.





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5. In the **Application Number** field, enter the application number provided during the initial enrollment.
6. In the **SSN/FEIN** field, enter the Social Security Number (SSN) or Federal Employer Identification Number (FEIN) used during the initial enrollment.
7. Select **Submit** to return to the application and make necessary adjustments.

The screenshot shows the 'Track Existing Application' form in the eCAMS HCEV system. At the top, there are navigation icons and a 'Profile' dropdown. Below that, there are 'Close' and 'Submit' buttons. A red circle with the number '7' is around the 'Submit' button. The main form area contains the text 'Please provide the Application Number and SSN/FEIN to track your application.' Below this text are two input fields: 'Application Number' and 'SSN/FEIN'. Red circles with the numbers '5' and '6' are placed over these input fields, with arrows pointing to them.

Note: All required steps in the application will be marked with the status of **Incomplete**. Each required step must be opened to verify the information is correct.

8. Open each step, verify the information is correct, and close the step. The step status will be marked **Complete**.

The screenshot shows the 'Enroll Provider - Individual' step in the application. At the top, there are navigation icons and a 'Profile' dropdown. Below that, there are 'Close', 'Required Credentials', and 'Purge' buttons. The main form area contains the text 'Business Process Wizard-Provider Enrollment (Individual). Click on the Step # under the Step column'. Below this text is a table with columns: Step, Required, Start Date, End Date, Status, and S. The table lists 13 steps. Step 8 is highlighted with a red circle and the number '8'.

Step	Required	Start Date	End Date	Status	S
Step 1: Provider Basic Information	Required	03/14/2021	03/14/2021	Incomplete	5
Step 2: Add Location	Required	03/14/2021	03/14/2021	Incomplete	
Step 3: Add Taxonomies	Required	03/14/2021	03/14/2021	Incomplete	
Step 4: Add Ownership Details	Optional	03/14/2021	03/14/2021	Complete	
Step 5: Add Licenses and Certifications	Required	03/14/2021	03/14/2021	Incomplete	
Step 6: Add Identifiers	Optional	03/14/2021	03/14/2021	Complete	
Step 7: Add EDI Submission Method	Optional	03/14/2021	03/14/2021	Complete	
Step 8: Add EDI Submitter Details	Required	03/14/2021	03/14/2021	Incomplete	
Step 9: Add EDI Contact Information	Required	03/14/2021	03/14/2021	Incomplete	
Step 10: Add Payment Details	Required	03/14/2021	03/14/2021	Incomplete	
Step 11: Complete Provider Disclosure	Required	03/14/2021	03/14/2021	Incomplete	
Step 12: View/Upload Attachments	Optional	03/14/2021	03/14/2021	Complete	
Step 13: Submit Enrollment Application for Review	Required	03/14/2021	03/14/2021	Incomplete	



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Note: After verifying the data in each step and making any required updates, the last step is to submit the enrollment application.

9. Select **Step 13: Submit Enrollment Application for Review.**

Step	Required	Start Date	End Date	Status
Step 1: Provider Basic Information	Required	03/14/2021	03/14/2021	Complete
Step 2: Add Location	Required	03/14/2021	03/14/2021	Complete
Step 3: Add Taxonomies	Required	03/14/2021	03/14/2021	Complete
Step 4: Add Ownership Details	Optional	03/14/2021	03/14/2021	Complete
Step 5: Add Licenses and Certifications	Required	03/14/2021	03/14/2021	Complete
Step 6: Add Identifiers	Optional	03/14/2021	03/14/2021	Complete
Step 7: Add EDI Submission Method	Optional	03/14/2021	03/14/2021	Complete
Step 8: Add EDI Submitter Details	Required	03/14/2021	03/14/2021	Complete
Step 9: Add EDI Contact Information	Required	03/14/2021	03/14/2021	Complete
Step 10: Add Payment Details	Required	03/14/2021	03/14/2021	Complete
Step 11: Complete Provider Disclosure	Required	03/14/2021	03/14/2021	Complete
Step 12: View/Upload Attachments	Optional	03/14/2021	03/14/2021	Complete
Step 13: Submit Enrollment Application for Review	Required	03/14/2021	03/14/2021	Incomplete

10. If there are any typographical errors, edit the first and last name in the **First Name** and **Last Name** fields.

11. (Optional) Enter the title of the individual signing the **Title** field.

12. To submit enrollment again, select **Submit Enrollment**. The enrollment application will change to **In Review** status.

After you submit the enrollment, you cannot make further changes until your enrollment application is approved.

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 prohibited from

First Name: * Last Name: *

Title: Signature Date: 10/31/2023

Privacy Act Statement

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