Workers' Compensation Medical Bill Processing System

How to Complete a Provider Enrollment Application
Facility Provider

Overview

This tutorial provides instructions on how to complete a provider enrollment application for a facility via the Workers' Compensation Medical Bill Processing (WCMBP) Portal.

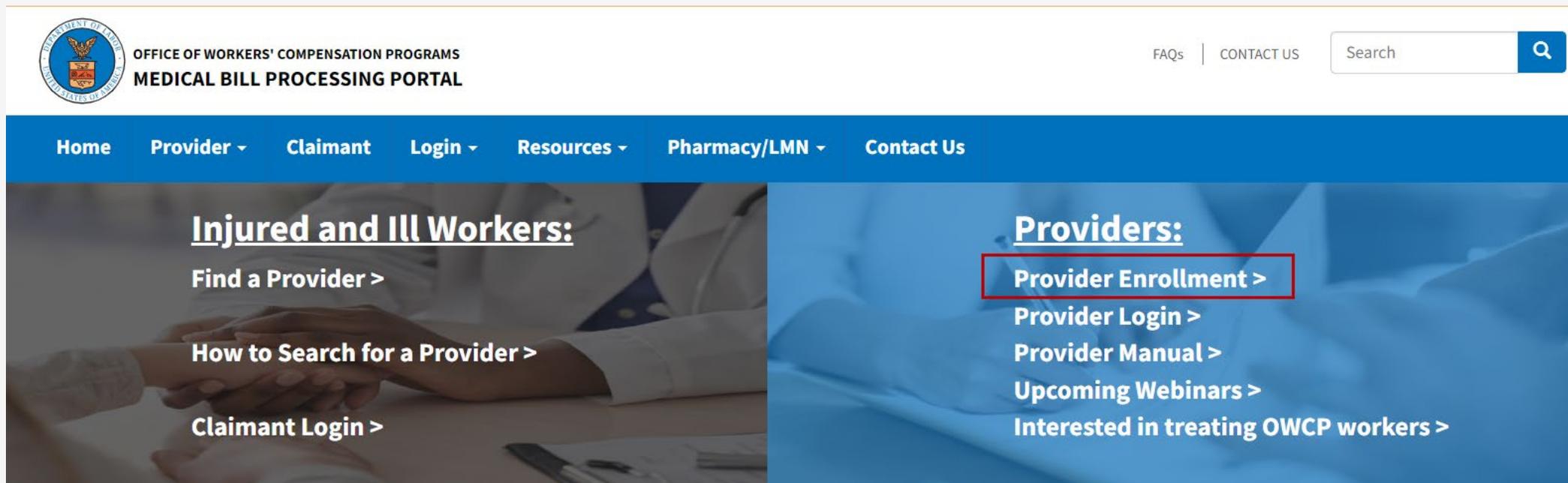Enrollment as a facility is defined as follows:

- An Inpatient or Outpatient Hospital, a Skilled Nursing Facility, an Intermediate Care Facility, a Clinic (RHC, FQHC, Hospital-Based Clinic, Urgent Care), a Psychiatric Facility, a Mental Institution, a Durable Medical Equipment Supplier, a Free Standing Ambulatory Surgical Center, a Long Term Care Facility, an Independent Clinical Laboratory, a Free Standing Radiology Clinic or Center, a Dialysis Center, a Partnership, a Corporation, or any other entity that furnishes or arranges for the furnishing of services for which payment is billed under the OWCP programs.

- It does not include individual practitioners or groups of practitioners; additionally, they must also be eligible to receive and currently possess a Type II National Provider Identifier, available through the NPPES.

1. Go to the WCMBP Portal Homepage (https://owcpmed.dol.gov).

2. Select **Provider Enrollment**.
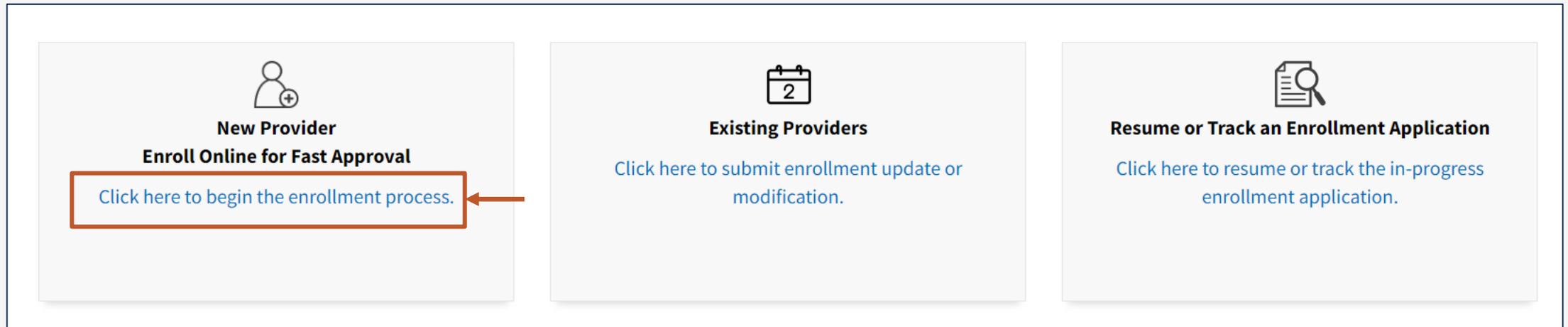
Note: If the Account Registration process has been completed, select here to continue to step 8 of the **OWCP Connect Account Registration** section of this tutorial.

3. Locate the **New Provider Enroll Online for Fast Approval** section and select the **Click here to begin the enrollment process** link.
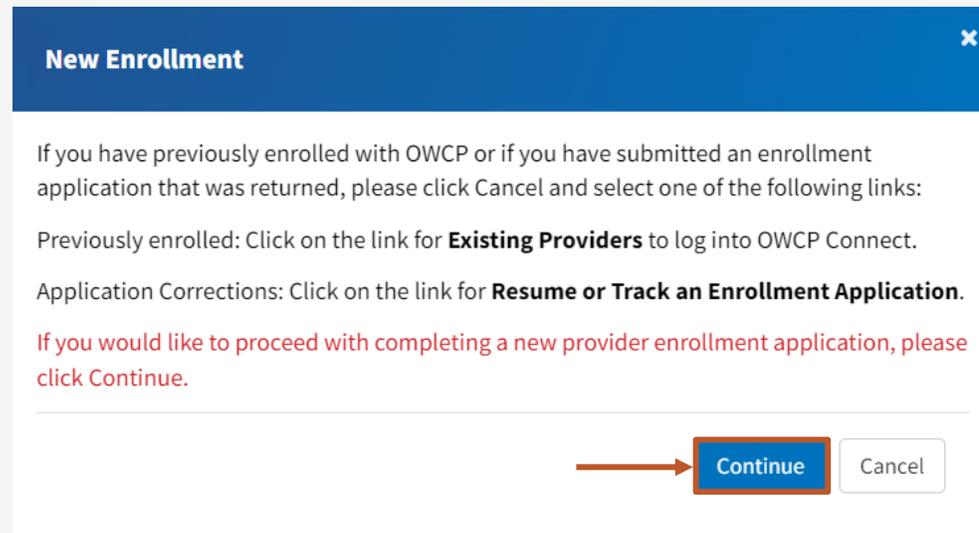
Note: A dialogue box appears, requesting confirmation to initiate a new enrollment.

4. To begin a new application, select **Continue**.

New Enrollment

If you have previously enrolled with OWCP or if you have submitted an enrollment application that was returned, please click Cancel and select one of the following links:

Previously enrolled: Click on the link for **Existing Providers** to log into OWCP Connect.

Application Corrections: Click on the link for **Resume or Track an Enrollment Application**.

If you would like to proceed with completing a new provider enrollment application, please click Continue.

Continue   Cancel

Note: Providers who previously enrolled and need to update enrollment or track an existing application need to select **Cancel** and then choose the appropriate "Existing Users" or "Resume or Track Enrollment Application" link.

1. To begin the OWCP Connect Account Registration process, on the OWCP Connect homepage, select **CREATE ACCOUNT** from the **New User** section.

2. Complete these fields:

- **First Name**

- **Last Name**

- **Email**

- **Retype Email**

- **Enter result of addition from image below**

Note: The **Middle Initial** field is optional.

3. Select **NEXT**.

Account Registration

Enter the below information to create the account

First Name*

Last Name*

Middle Initial

Email*

Consider using an email address that is not associated with your current employment.

This email is available.

Retype Email*

This email is available.

Enter result of addition from image below*

3   3
  +
6

* Required Field

NEXT

Instructions

Please enter the required information and click NEXT to begin the Account Registration process.

NOTE: When entering SSN and Primary Phone, only enter numerical characters. Do not include special characters, like - and (). For example, for the SSN 123-45-6789, you would enter 123456789 in the field.

This information is necessary to access personal Credit Bureau data for purposes of Identity Verification. All data transactions are secure and private.

4. Enter a valid password based on the password instructions in the **Password** and **Retype Password** fields.

5. Select **NEXT**.

Note: The **Email** field automatically populates based on the previous step.

Note: Select **PREV** to return to the previous step.

6. Select a **Security Image**.

7. Enter a key phrase in the **Key Phrase** field.

8. Select **NEXT**.

Note: Select **PREV** to return to the previous step.

9. Select three **Security Questions** and enter the answers in the corresponding fields.

10. Select **SUBMIT**.

Note: Select **PREV** to return to the previous step.

Upon submitting the Account Registration request, the system provides notification that the account creation request has been submitted successfully. The system will send an email to the email address provided including a link used to activate the account.

The link provided in the email is available for 24 hours.

Account Creation

Your account creation request has been submitted successfully.

An email has been sent to the email address you provided, which includes a link that you will need to click in order to activate your account. The link provided in the email is available for 24 hours.

Instructions

You will be receiving a confirmation email shortly.

You must activate your account by clicking on the link provided in the email.

11. Access the notification email from the email address provided.

12. To activate the account, select the **here** link from the email. *This step is required to activate the account.*

The link takes navigates to OWCP Connect where notification displays under the **Existing User** section that the account has been successfully activated.

Note: The registration process is completed only once. After the account is successfully activated, logging into the WCMBP System for Provider Enrollment can be done from the **Existing User** section.

13. Enter the email address registered in the **Login Using Email Address** field.

14. Select **LOGIN**.

Note: Providers already registered can log in using OWCP Connect.
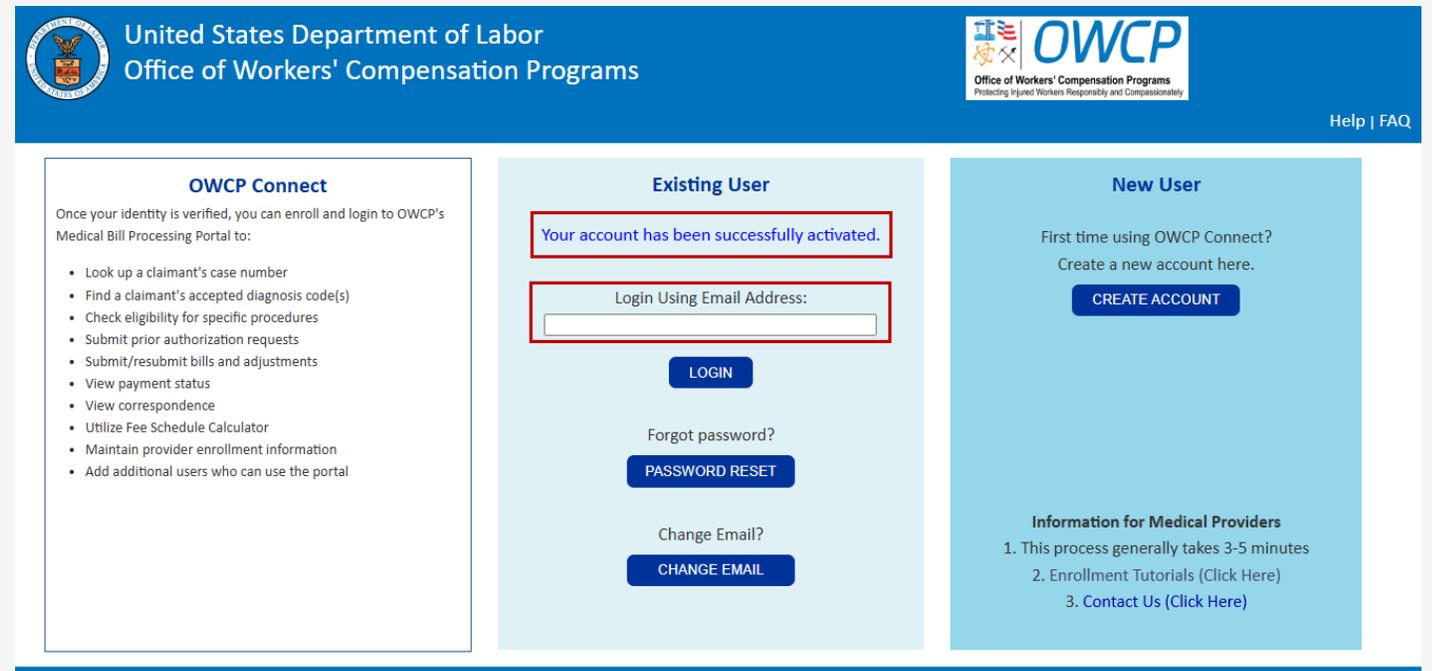
United States Department of Labor
Office of Workers' Compensation Programs

OWCP
Office of Workers' Compensation Programs
Protecting Injured Workers Responsibly and Compassionately

Help | FAQ

OWCP Connect

Once your identity is verified, you can enroll and login to OWCP's Medical Bill Processing Portal to:

- Look up a claimant's case number
- Find a claimant's accepted diagnosis code(s)
- Check eligibility for specific procedures
- Submit prior authorization requests
- Submit/resubmit bills and adjustments
- View payment status
- View correspondence
- Utilize Fee Schedule Calculator
- Maintain provider enrollment information
- Add additional users who can use the portal

Existing User

Your account has been successfully activated.

Login Using Email Address:

LOGIN

Forgot password?
PASSWORD RESET

Change Email?
CHANGE EMAIL

New User

First time using OWCP Connect?
Create a new account here.

CREATE ACCOUNT

Information for Medical Providers
1. This process generally takes 3-5 minutes
2. Enrollment Tutorials (Click Here)
3. Contact Us (Click Here)

15. Enter the password in the **Password** field.

16. Select **SUBMIT**.

1. Select the applicable **Enrollment Type**.

2. Select **Submit**.

Note: Enrollment Type definitions are provided on the bottom portion of the screen. Select the appropriate type for the practice, organization, or business.

After selecting the enrollment type, the **Step 1: Provider Basic Information** page displays.

3. Select a provider type from the **Provider Type** drop-down list.

Note: If Other Provider (96) or Non-Medical Vendor (53) is selected as the **Provider Type**, the following text field becomes required for an explanation.

4. In the **Program** field, select the checkbox next to all the desired programs to enroll.

Note: At least one program must be selected. Multiple selections are allowed.

5. Complete these fields:

   - **Organization Name** (Legal Business Name)

   - **Organization Business Name** (Doing Business As)

   - **FEIN** (Federal Employer Identification Number)

Note: The system will validate that the Name and Tax Identification Number combination matches IRS records.

6. If required, enter a National Provider Identifier (NPI) in the **National Provider Identifier** field.

Note: Refer to OWCP-1168 Appendix 3 to confirm if NPI is required.

7. An entity type should be selected from the **Entity Type** drop-down list based on the W9.

Note: If **Other** as the **Entity Type** was selected, the **If Other, please explain** field is required.

8. Enter a valid email address in the **Email Address** field (optional).

9. A decision should be made regarding whether to be included in an online searchable list of OWCP providers:

   ▪ If yes, proceed to the next step.

   ▪ If no, to be excluded from the online searchable listing of OWCP providers, select the checkbox below the **Entity Type** field and provide a reason in the **Reason** field.

10. Select **Finish**.

11. Write down the application number for records and select **Ok**.

Note: The application number will also be emailed to the email address provided in the Provider Basic Information step.

After completing **Step 1: Provider Basic Information**, the page will display all the steps for the enrollment process.

Note: To successfully submit the application, all **Required** steps must be completed.

Note: If the incorrect enrollment type was selected, select **Delete** to delete all information and restart the enrollment application.

Note: Exiting the application and returning later to complete and submit is possible. For details, refer to **Resume or Track Application** here.

New Enrollment › FAOI Enrollment						
Application Number:		Name:			Enrollment Type: Facility/Agency/Organization/Institution	
Close	Required Credentials	Delete				
Enroll Provider -Facility/Agency/Organization/Institution						

Business Process Wizard – Provider Enrollment (Facility/Agency/Organization/Institution). In order to submit your application, please click the last step for **Submit Enrollment Application for Review.**

Step ▲▼	Required ▲▼	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	03/18/2025	03/18/2025	Complete	
Step 2: Add Location	Required			Incomplete	
Step 3: Add Taxonomies	Required			Incomplete	
Step 4: Add Ownership Details	Optional			Incomplete	
Step 5: Add Business Licenses and Certifications	Required			Incomplete	
Step 6: Add Identifiers	Required			Incomplete	
Step 7: Add EDI Submission Method	Optional			Incomplete	
Step 8: Add EDI Submitter Details	Optional			Incomplete	
Step 9: Add EDI Contact Information	Optional			Incomplete	
Step 10: Add Payment Details	Required			Incomplete	
Step 11: Complete Provider Disclosure	Required			Incomplete	
Step 12: View/Upload Attachments	Optional			Incomplete	
Step 13: Submit Enrollment Application for Review	Required			Incomplete	

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

12. After completing **Step 1: Provider Basic Information**, and before proceeding to **Step 2: Add Location**, select **Required Credentials**. A separate window opens over the existing window displaying the credentials that are required for the provider type.
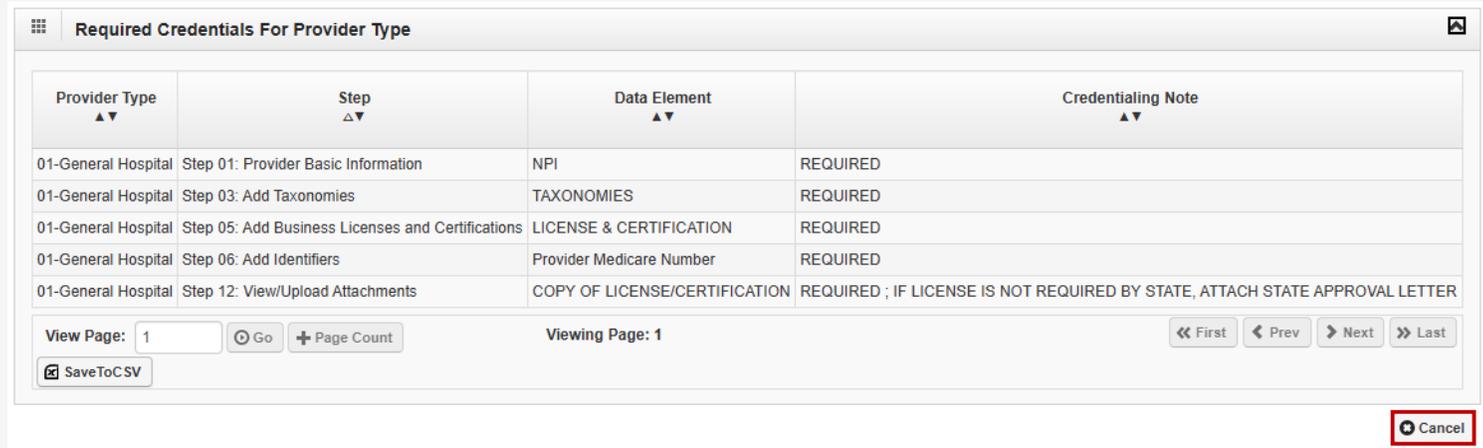
Note: Credentials requirements will change based on the selected provider type.

13. To exit this credentials window and move on to the next step, select **Cancel**.

Required Credentials For Provider Type

Provider Type	Step	Data Element	Credentialing Note
01-General Hospital	Step 01: Provider Basic Information	NPI	REQUIRED
01-General Hospital	Step 03: Add Taxonomies	TAXONOMIES	REQUIRED
01-General Hospital	Step 05: Add Business Licenses and Certifications	LICENSE & CERTIFICATION	REQUIRED
01-General Hospital	Step 06: Add Identifiers	Provider Medicare Number	REQUIRED
01-General Hospital	Step 12: View/Upload Attachments	COPY OF LICENSE/CERTIFICATION	REQUIRED ; IF LICENSE IS NOT REQUIRED BY STATE, ATTACH STATE APPROVAL LETTER

View Page: 1 ⊙ Go + Page Count   Viewing Page: 1   « First ‹ Prev › Next » Last

🗎 SaveToCSV

⊙ Cancel

1. Select **Add**.
2. Enter the location in the **Business Name** field.
3. Enter the contact's last name and first name in the **Contact Last Name** and **Contact First Name** fields.
4. Enter the contact's phone number (excluding dashes or spaces) in the **Phone Number** field.
Note: The **Fax Number** field is optional.
5. Enter the contact's email address in the **Email Address** field.
6. To opt-in for paperless correspondence, select the checkbox below the **Email Address** field.
Note: When the checkbox is selected, the **Email Address** field becomes mandatory.
7. Select **Next**.

Note: The physical address must be added, *this step is required*. The address fields are initially disabled.

8. To enter address details, select **+Address**. The **Address Details** window opens over the existing screen.

Note: If **Next** is selected prior to adding the physical address, an error message window will display stating "Address is mandatory. Please enter an address." Select **OK** to close the error message and add the address.

9. Enter the street number and name in the **Address Line 1** field.

10. Enter the zip code in the **Zip Code** field.

11. Select **Validate Address**.

Note: The full address populates if the address can be validated.

Note: If the address cannot be validated, an alert window opens. Select **OK** to continue or select **Cancel** to revalidate the address.

12. To add the Physical Address, select **OK**.

13. To enter the Mailing Address, select **Next**.

14. Proceed based on the mailing address:
   - If the mailing address *is the same as the physical address*, select the **Same as Physical Address** radio button.
   - If mailing address *is different from the physical address*, select **+Address** to open a new window to manually input the Mailing Address.
     Note: This is the same process as adding Physical Address.
15. Select **OK**.
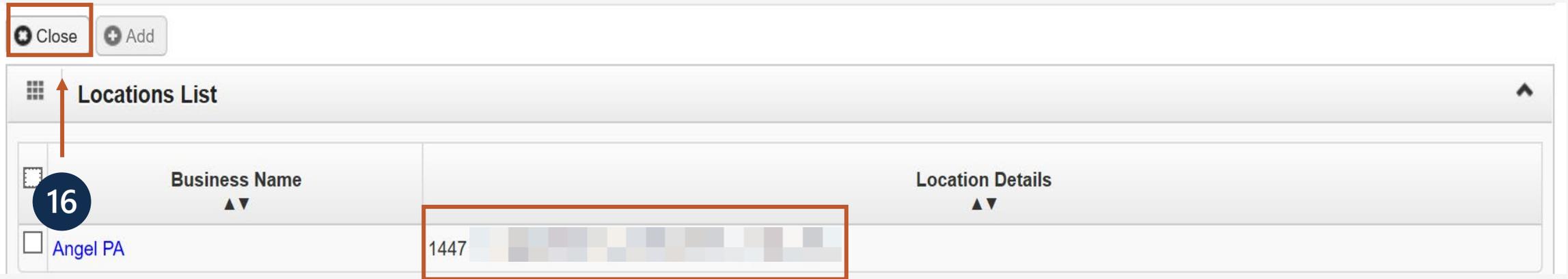
The **Locations List** displays the entered address information.

16. To move on to the next step, select **Close**.

1. To add taxonomy codes, select **+Add**.

The **Add Taxonomy Code** page opens.
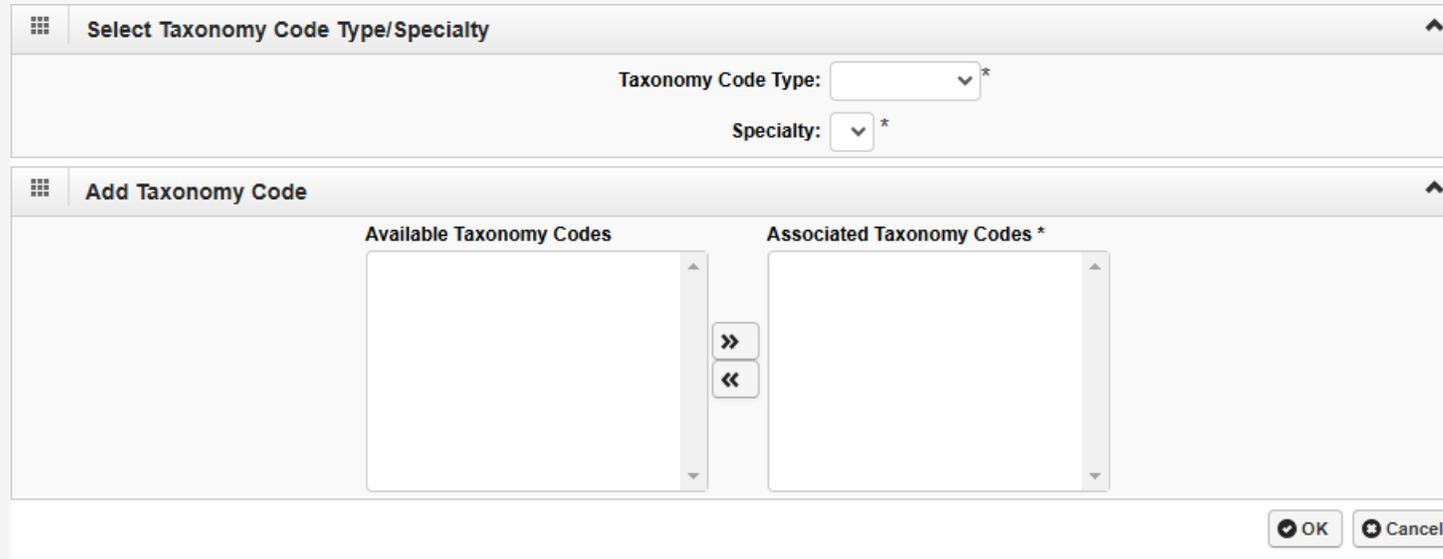
2. From the **Taxonomy Code Type** drop-down list, select the applicable taxonomy code type.
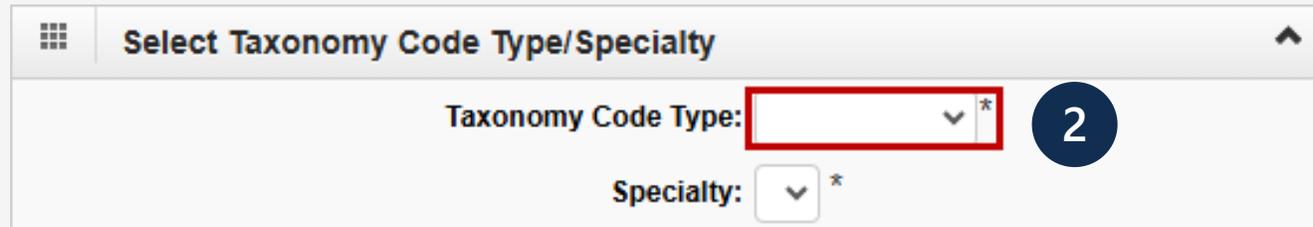
3. From the **Specialty** drop-down list, select the specialty type.

4. Highlight the applicable codes from the **Available Taxonomy Codes** that populate, then select the double right-facing arrow to move them to the **Associated Taxonomy Codes** box.
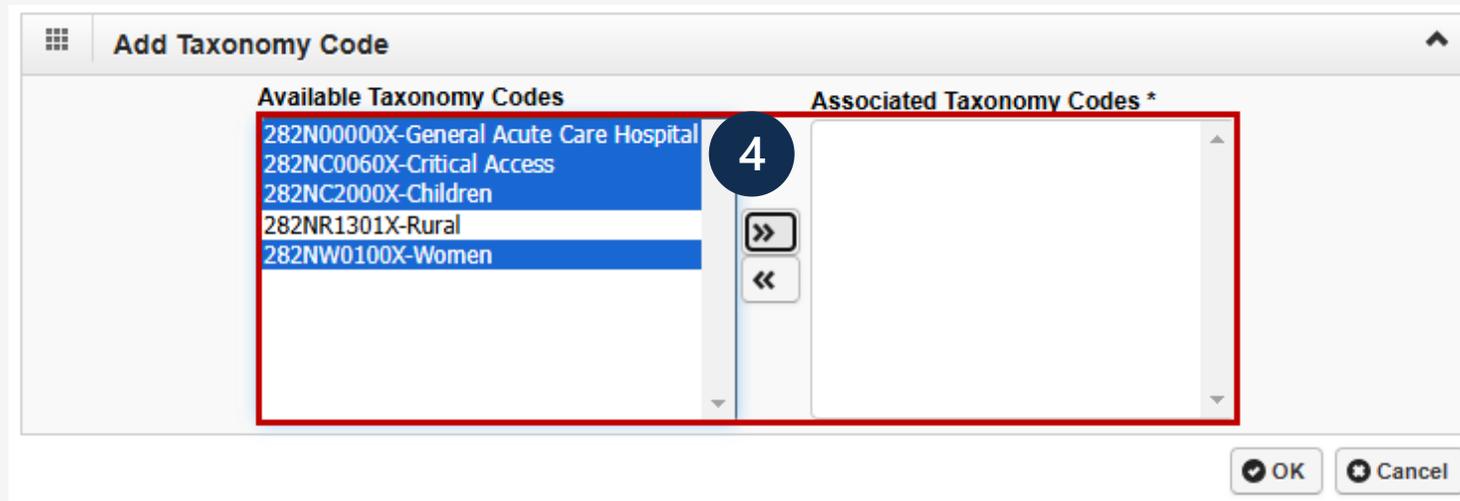
Note: Select multiple codes at a time by pressing and holding the **Ctrl** key while selecting multiple codes at one time. Select the double left-facing arrows to remove codes from the **Associated Taxonomy Codes** box back into the **Available Taxonomy Codes** box, if necessary.

5. Select **OK**.

6. Once all associated Taxonomies have been selected, select **Close** to move on to the next step.

This step is optional. If completed, enter the information in the required fields and select **OK**.

1. Select **Add**.
2. Select the (individual or organization) ownership from the **Ownership Type** drop-down list.
3. Enter the Social Security Number (SSN) or Federal Employer Identification Number (FEIN) in the **SSN/FEIN** field.
4. Enter either the organization name in the **Organization Name** field or the last name and first name in the **Last Name** and **First Name** fields.
5. Select **+Address** to open the **Address Details** window.
   a. Enter the street number and name in the **Address Line 1** field.
   b. Enter the zip code in the **Zip Code** field.
   c. Select **+Validate Address** to populate address details.
   d. To close the window, select **OK**.
   Note: The full address populates if the address can be validated.
   Note: If the address cannot be validated, an alert window opens. Select **OK** to continue or select **Cancel** to revalidate the address.
6. Select **OK**.

Note: If the ownership information is the same name, FEIN, and address as previously entered in the **Provider Basic Information** step, select **Copy Name and Tax** to auto-populate the information.

The **Ownership List** displays the entered Ownership information.

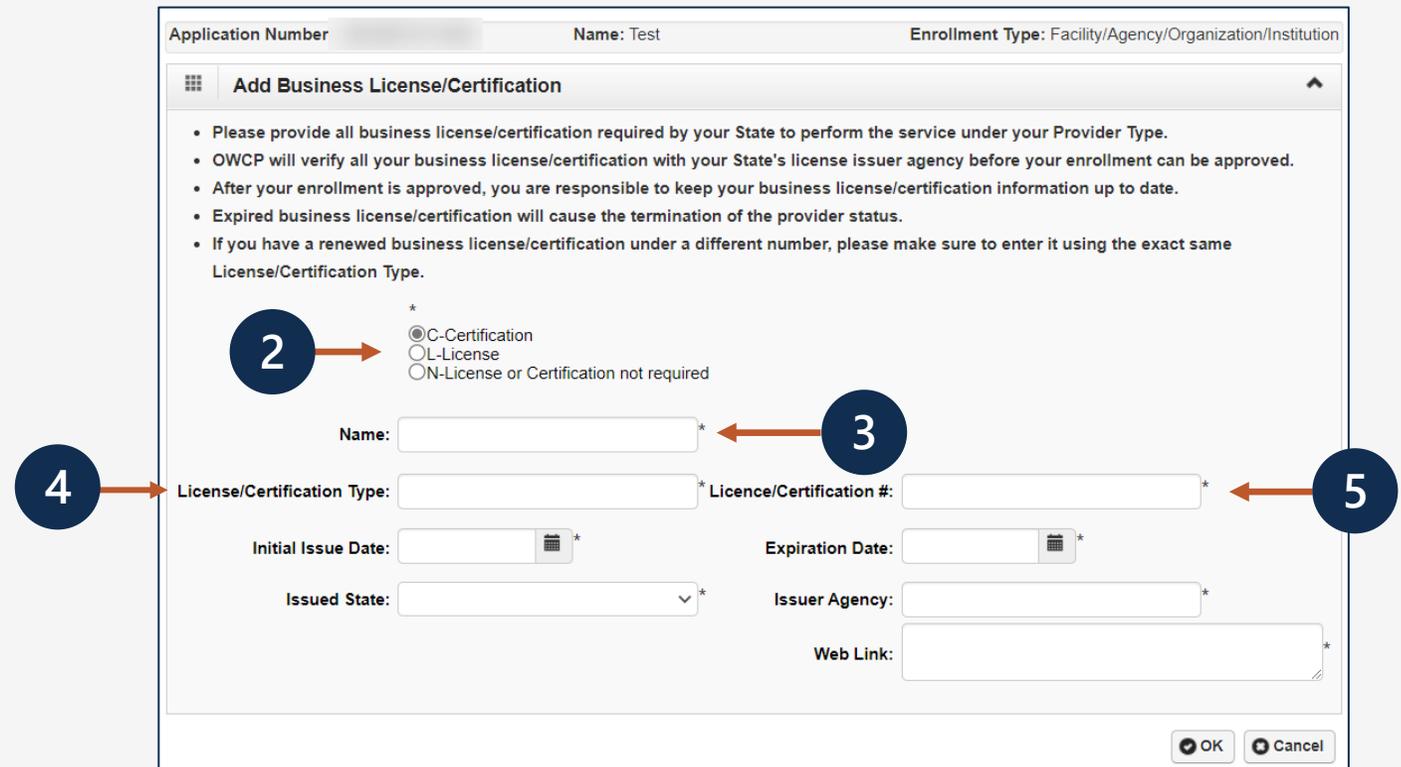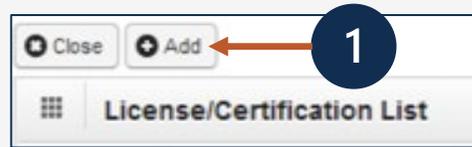7. To move on to the next step, select **Close**.

1. To enter the License or Certification information, select **+Add**.

2. Select the applicable option:
   - C-Certification
   - L-License
   - N-License or Certification not required

3. In the **Name** field, enter the business name as it appears on the license or certification.

4. In the **License/Certification Type** field, enter the license or certification type.

   Note: This is a free form text field.

5. In the **License/Certification #** field, enter the license or certification number.

6. In the **Initial Issue Date** field, enter or select the initial issue date.

7. In the **Expiration Date** field, enter or select the expiration date.

8. From the **Issued State** drop-down list, select the state where the license or certification was issued.

Note: The Issued State must match the state of physical address.

9. Enter the issuing agency in the **Issuer Agency** field.

10. In the **Web Link** field, enter the web address of the issuing agency.

11. Select **OK**.

Add Business License/Certification

- Please provide all business license/certification required by your State to perform the service under your Provider Type.
- OWCP will verify all your business 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 business license/certification information up to date.
- Expired business license/certification will cause the termination of the provider status.
- If you have a renewed business license/certification under a different number, please make sure to enter it using the exact same License/Certification Type.

*
○ C-Certification
○ L-License
○ N-License or Certification not required

Name:

License/Certification Type: Licence/Certification #:

6 → Initial Issue Date: 7 → Expiration Date:

8 → Issued State: Issuer Agency: ← 9

10 → Web Link:

11 → OK   Cancel

Note: If **N-License or Certification not required** is selected, an explanation is required. Enter an explanation in the provided field.

The **License/Certification List** displays the entered license or certification information.
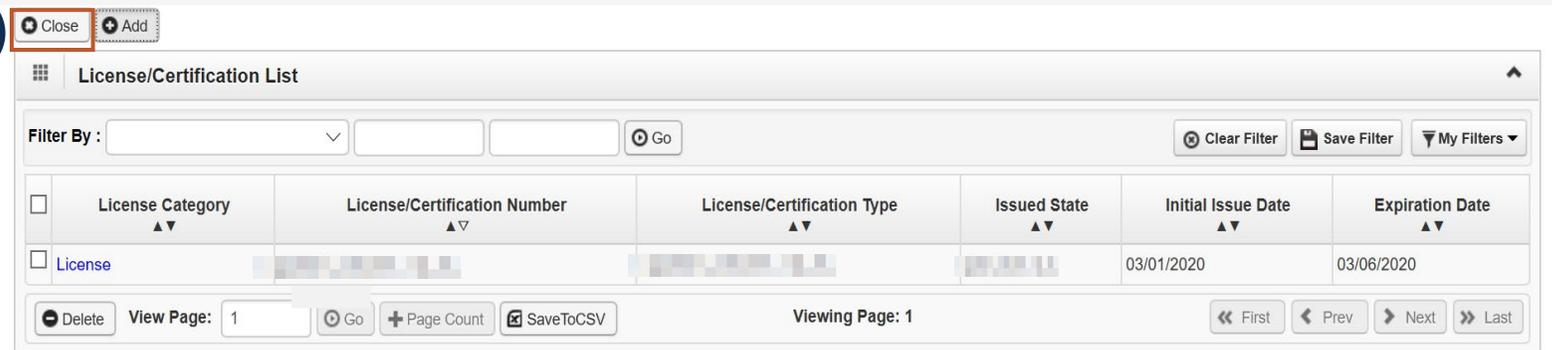
Note: Add all business licenses or certifications required by the State to perform the service under the Enrollment Provider Type.

12. To move on to the next step, select **Close**.

Step 6: Add Identifiers (1 of 2)

1. Select **+Add**.
2. Select the identifier type from the **Identifier Type** drop-down list.
3. Enter the identifier value in the **Identifier Value** field.
4. Enter or select the start and end dates in the **Start Date** and **End Date** fields.
5. Select **OK**.

Note: This step may be required for the provider type entered in **Step 1: Provider Basic Information**. Select **Required Credentials** to determine if the provider type requires an identifier.

The **Provider Identifiers** list displays the entered identifier information.

6. To move on to the next step, select **Close**.

1. Select the checkbox next to the applicable **Mode of Submission**. *More than one Mode of Submission may be selected.*

Note: Electronic Data Interchange (EDI) is the computer-to-computer exchange of business documents in a standard electronic format between business partners. If Billing Agent/Clearinghouse as the Mode of Submission is selected, the Billing Agent/Clearinghouse OWCP ID in **Step 8: Add EDI Submitter Details** is required.

Note: If the Billing Agent or Clearinghouse OWCP provider ID is not available at the time of completing the application, select **Paper**. This information can be updated after enrollment as an active OWCP provider.
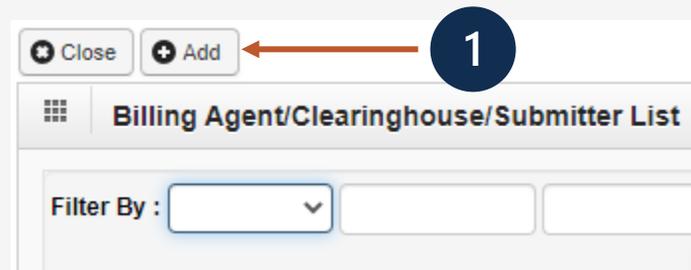
2. To move on to the next step, select **OK**.

Note: The Billing Agent or Clearinghouse must be enrolled with OWCP first. Contact the Billing Agent or Clearinghouse for their OWCP ID to complete this section.

Note: If Billing Agent/Clearinghouse is selected as the EDI Submission Method in **Step 7: Add EDI Submission Method**, then **Step 8: Add EDI Submitter Details** is required.

1. Select **+Add** on the **Billing Agent/Clearinghouse/Submitter List** page.

Note: If the Billing Agent or Clearinghouse OWCP provider ID is not available at the time of completing the application, select **Close** to return to the previous step, then deselect Billing Agent/Clearinghouse and select Paper or a different mode of submission. This information can be updated after enrollment as an active OWCP provider.

2. Enter the Billing Agent or Clearinghouse OWCP ID in the **Billing Agent/Clearinghouse OWCP ID** field.

3. Enter the start and end dates in the **Start Date** and **End Date** fields.

Note: This identifies the effective date and end date for the association with the clearinghouse. Start Date is required, but End Date is optional. If End Date is left blank, the field will show 12/31/2999.

4. Select **OK**.

The **Billing Agent/Clearinghouse/Submitter List** page displays the entered OWCP ID information.

5. To move on to the next step, select **Close**.
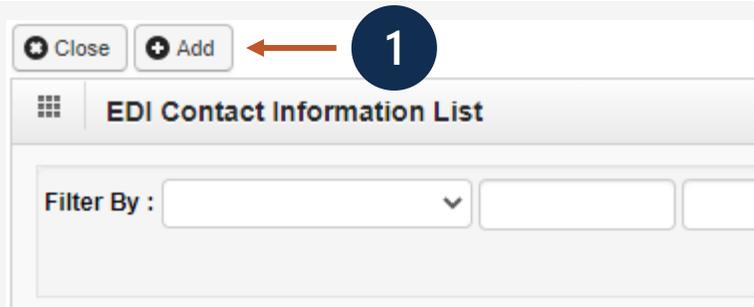
Note: Step 9: Add EDI Contact Information is required if FTP Secured Batch or Web Batch was selected in **Step 7: Add EDI Submission Method**. EDI Contact Information must be on file if we need to ask the Billing Agent or Clearinghouse any questions pertaining to their EDI enrollment or future submissions and retrievals.

1. Select **Add** on the **EDI Contact Information List** page.

2. Enter the title of the contact person to answer EDI questions in the **Contact Title**, field if needed.

3. Enter the contact person's last and first names in the **Last Name** and **First Name** fields.

4. Enter the contact person's 10-digit phone number in the **Phone Number** field.

Note: Fax Number and **Email Address** fields are optional.

5. Select **+Address**. The **Address details** window opens.
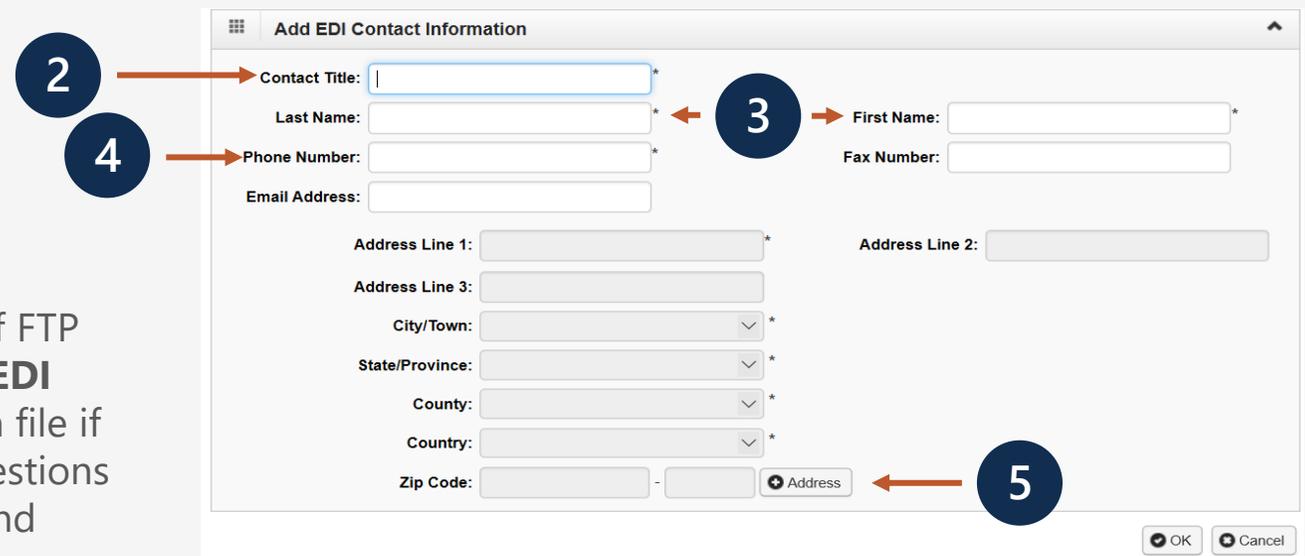
Note: This step is required if Secured Batch or Web Batch was selected in **Step 7: Add EDI Submission Method**.

6. Enter the street number and name in the **Address Line 1** field.

7. Enter the zip code in the **Zip Code** field.

8. Select **Validate Address**.

Note: The full address populates if the address can be validated.

Note: If the address cannot be validated, an alert window opens. Select **OK** to continue or select **Cancel** to revalidate the address.

9. Select **OK**.

10. To complete the EDI Contact Information entry, select **OK**.

The **EDI Contact Information List** displays the entered contact information.

11. To move on to the next step, select **Close**.

Note: Electronic Funds Transfer (EFT) is mandatory. Payment Details must be entered to receive payment from OWCP.

1. Select **+Add**.

The **Payment Details and Financial Institution Information page** opens.

2. Complete the **Financial Institution Name** field (required).
3. Complete the **Nine-Digit Routing Transit Number** field (required).

4. Complete the **Financial Institution ACH Coordinator Name** field.
5. Complete the **Phone Number** field (optional).

6. Enter the account number in the **Depositor Account Number** field.

7. Select the account type (Checking or Savings) from the **Type of Account** drop-down list.

8. Enter the name associated with the bank account in the **Depositor Account Title** field.

9. Select **+Address** to add the Financial Institution address. The **Address Details** window opens.

    a. Enter the street number and name in the **Address Line 1** field.

    b. Enter the zip code in the **Zip Code** field.

    c. Select **Validate Address**.

    Note: The full address populates if the address can be validated.

    Note: If the address cannot be validated, an alert window opens. Select **OK** to continue or select **Cancel** to revalidate the address.

    d. Select **OK**.

10. Once the address is added, select the **Signed by Representative** checkbox.

11. Enter the title of the financial institution's representative or provider practice representative in the **Title of Representative** field.

12. Enter the representative's phone number in the **Representative Phone Number** field.

13. Select **OK**.

Note: An alert window opens stating "Please note: Acentra Health will make two phone call attempts to reach the contact identified on the signed ACH form. Failure to answer and verify banking details may result in a rejection of your enrollment application."

14. To acknowledge, select **OK**.

The **Payment Details** List displays all entered payment information.

15. To move on to the next step, select **Close**.

Step 11: Complete Provider Disclosure

1. Answer the disclosure question. If **Yes** is selected, a comment is required.

Note: FECA DME Provider Type 75 must answer an additional disclosure question.

2. Select **Save**.

3. To move on to the next step, select **Close**.

Note: In this step, upload required attachments (via Direct Data Entry or DDE). If attachments are not uploaded at the time of submission, the option to mail or fax required attachments with a provider enrollment cover sheet is available. The application will stay in an "Awaiting Attachments" status for nine days. If the attachments and cover sheet are not received within this timeframe, the application will be Returned to Provider (RTP). Select **Required Credentials** to check which attachments are required for Provider Type.

1. Select **Upload Attachments**.

2. Select the document type from the **Document Type** drop-down list.

3. Select **Choose File**. The system opens the **Open** window.

4. The file should be located and selected from the local drive, followed by selecting **Open**. The system then updates the **File Name** field.

5. Select **OK**.

The **Attachment List** displays the uploaded attachments.

6. Repeat the Upload Attachment steps on the previous slide for multiple attachments.

7. To move on to the next step, select **Close**.
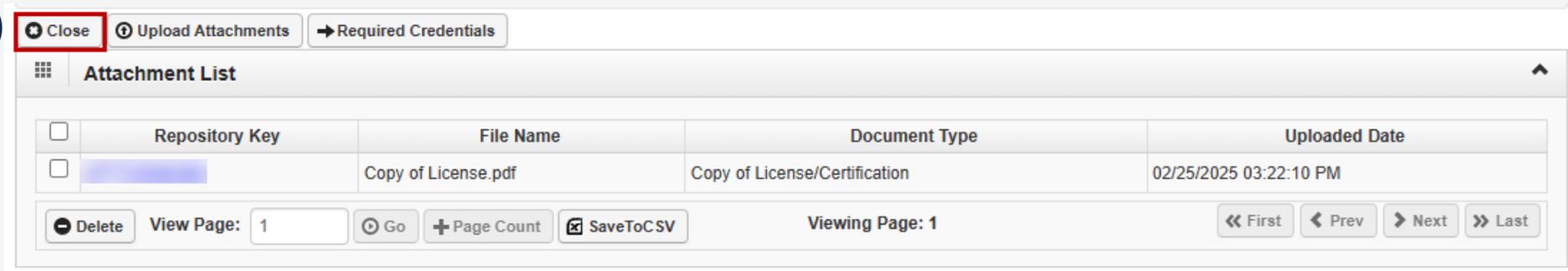
Verify Information Before Submission

1. To verify information entered and make any needed corrections prior to submission, select the link for any of the previous steps.

2. Select the link within the step to review the information entered or make corrections if needed.

The **First Name** and **Last Name** fields populate based on the OWCP Connect ID. If the either field is edited, an alert displays, select **OK** to submit or **Cancel** to return to the signature.

1. Enter the title of the signer in the **Title** field (optional).

Note: The **Signature Date** field shows the current date and cannot be changed.

2. At the bottom of the screen, select **Submit Enrollment**.

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: 02/25/2025 15:45:28
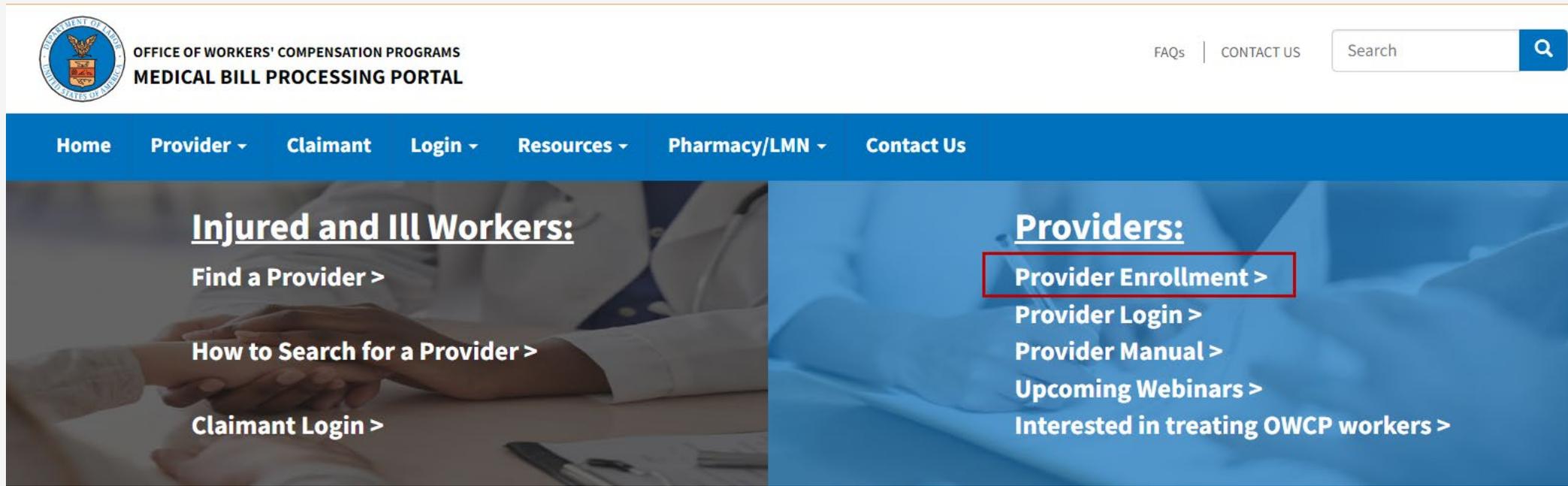
1

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.

2   ⊘ Close   ⊘ Submit Enrollment

Note: When an application is successfully submitted, the **Submit Enrollment** button will become disabled.

Note: In-progress Enrollment Applications can be resumed or tracked.

1. Go to WCMBP Portal Homepage (https://owcpmed.dol.gov).

2. Select **Provider Enrollment**.

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

4. Log in using the OWCP Connect email address and password.

5. Proceed as applicable:

   ▪ If known by the provider, complete the **Application Number** and **SSN/FEIN** fields, then proceed to the next step.

   ▪ If the **Application Number** and **SSN** or **FEIN** are not known, select the **Application Number Lookup** link and proceed to the next slide.

6. To return to the in-progress enrollment application, select **Submit**.

7. To retrieve the **Application Number**, enter the National Provider Identifier (NPI) and Social Security Number (SSN) or Federal Employer Identification Number (FEIN) in the **National Provider Identifier** and **SSN/FEIN** fields.

8. To view the application number, select **Submit**.

Note: The system identifies the matching enrollment applications and displays the application's details in the **Enrollment Applications** section below the **Application Number Lookup**.

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

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

Post-Submission Key Timeframes

Once the application is submitted for review, the processing timeframes are as follows:

- **Attachments Received:** Processing time is seven business days from the date the application and attachments are received.

- **Awaiting Attachments:** The required documents have not been received. The application will remain in this status for nine days from the date the application was submitted. The documents may be sent via fax or mail.

- **Attachments Not Received:** The application will be Returned to the Provider after the nine days of Awaiting Attachments status.

Attachment Submission Options

If mailed or faxed, submit all enrollment supporting documentation with a Provider Enrollment Supporting Documents Cover Sheet available on the WCMBP Portal.

Via Mail
Provider Enrollment
Department of Labor OWCP
PO Box 8312
London, KY 40742-8312

Via Fax
888.444.5335