Miner Medical Reimbursement Form

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

NOTE: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No.: 1215-0052
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NOTE: This report is authorized by law (30 U.S.C. 901 et.seq.) and is required to receive a benefit. While you are not required to respond, reimbursement for Black Lung related medical expenses may not be made unless this form is completed. Disclosure of your Social Security Number is voluntary. The failure to disclose this number will not result in the denial of any right, benefit or privilege to which you may be entitled. This method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir.No. 108. This form is only to be used for requesting reimbursement of the coal miner's medical expenses payable under the Federal Black Lung Benefits Act.

1. Miner's Name (Last, First, MI)	2. Miner's Social Security Number
3. Payee's Name (Last, First, MI) if other than miner	4. Payee's Telephone Number ( )

5. Payee's Address (Number and Street/RFD, City, State, ZIP Code)

SPECIAL INSTRUCTIONS:

1. See reverse side of form for **COMPLETE INSTRUCTIONS AND REQUIREMENTS FOR ATTACHMENT OF BILLS/RECEIPTS.**
2. Please list below only charges that you paid related to medical services covered under the Black Lung Program. Use a separate line for each type of service.

6. Name of Provider Making the Charge (Doctor, Hospital, Pharmacy, etc.)	Description of Charge (name of prescription drug, office visit, durable med. equipment e.g., oxygen, bed, commode, etc.)	Date of Service or Purchase (Month, day, year, if there is only one date, show it under "From")		Amount Paid by Miner/Payee	FOR DOL USE ONLY	
		From	To		A	B

Total amount Paid by Miner or Authorized Payee: $ _____

7. I certify that the information above is correct and that reimbursement requested is for expenses paid by the miner or the authorized payee named above for treatment of the miner's black lung condition or for authorized medical evidence provided in the development of a black lung claim. I am aware that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under Title 30 USC 941 shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine of not more than $1,000, or by imprisonment for not more than one year or both.

   I authorize any provider named in item 6 to release information to the Federal Black Lung Program if necessary for the proper adjudication of this claim.

   Payee's Signature: _____ Date: _____

8. MAIL THIS COMPLETED FORM WITH ITEMIZED BILLS AND RECEIPTS SECURELY ATTACHED TO:

Federal Black Lung Program
P.O. Box 828
Lanham - Seabrook, MD 20703-0828

INSTRUCTIONS FOR USE OF FORM CM-915

Filing Limitations: Requests for reimbursement of expenses paid by a miner or authorized payee for treatment of the miner's black lung condition should only be submitted to this Program when the miner has been awarded medical benefits under the Black Lung Benefits Act, no coal mine operator has assumed liability for benefit payments and no benefits related to treatment of a black lung condition are payable under a state workers' compensation program. (Requests for reimbursement of expenses associated with providing authorized medical evidence must be coordinated through the appropriate Black Lung district office).

Who Must Complete Form CM-915: Coal miners, survivors and representative payees must complete this form when seeking reimbursement for expenses incurred in the treatment of a miner's black lung condition or when providing authorized medical evidence in the development of a claim. Survivors and representative payees must have authorized payee documentation on file with the appropriate Black Lung district office prior to filing for reimbursement on behalf of a miner.

DOCUMENTATION REQUIRED FOR REIMBURSEMENT OF MEDICAL EXPENSES:

1. **Prescription Drugs:**

   Pharmacist's **original** billhead, e.g. pharmacy bag, must include the following information:

   - Name, address and Social Security Number for miner.
   - Name of physician who prescribed the drug(s) for miner.
   - Eleven digit National Drug Code (NDC).
   - Prescription number.
   - Amount prescribed - mgm/ml or cc and total ml or cc per bottle for liquid medication and/or mgm per tablet and total number of tablets per prescription.
   - Date purchased.
   - Name and charge for each drug.
   - Amount actually paid by miner or authorized payee.

   An itemized list or computerized printout on a pharmacy's original billing form is acceptable providing the list or printout includes all of the data specified above and the pharmacist's original signature.

Note: Non-prescription drugs are not covered.

2. **Medical Expenses other than Prescription Drugs:**

   a. Bills may be on a HCFA 1500 or the health care provider's letterhead stationery. The following information must be included:

      - Name and address of the physician, hospital or other health care provider.
      - Full name, address and Social Security Number for miner.
      - Medical condition treated for each type of service or supply provided other than bills for CMN related supplies and services listed in item 2c.
      - Date each service or supply provided.
      - Description (coded by CPT-4 if possible) and charge for each type of service or supply provided.
      - Amount actually paid by the miner or authorized payee.

Note: In addition to an itemized bill, an admitting diagnosis(es), summary of charges, and a discharge summary are required for reimbursement of inpatient hospital expenses.

   b. Proof of payment indicating that the miner or authorized payee paid all or a portion of the bill:

      - an itemized bill on the provider's billhead including the original signature of the provider, diagnosis(es), and the amount paid by the miner or authorized payee, or
      - the provider's official receipt form signed by the provider indicating date(s) and type(s) of service or supply provided, diagnosis(es), and the amount paid by the miner or authorized payee.

   c. An approved Certificate of Medical Necessity must be on file at the Department of Labor for reimbursement of durable medical equipment, pulmonary rehabilitation and home health care services.

3. **Travel expenses:**

   Reimbursement requests should be submitted on Form CM-957, the Medical Travel Refund Request Form which may be obtained by calling the toll free number listed below.

Note:
- The miner's Social Security Number should be on all attachments.
- Form CM-915 will be returned to the payee requesting reimbursement if completed incorrectly or required documentation specified above is not submitted with form.
- Payment of bills can usually be submitted directly to the Black Lung Program by the provider rendering service.

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All questions concerning medical reimbursements may be answered by calling toll free: **1-800-638-7072** (within the United States).

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation , Room C-3526, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE