U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

DEEOIC MEDICAL BENEFITS

Frequently Asked Questions Regarding the Division of Energy Employees Occupational Illness Compensation's (DEEOIC) Medical Benefit Authorization Process

INTRODUCTION

This brochure provides information to claimants for whom the DEEOIC has awarded medical benefits under the **Energy Employees Occupational Illness Compensation Program Act** (EEOICPA). An employee who meets the legal conditions of coverage is entitled to medical care consisting of services, appliances, supplies, and home/vehicle modifications or travel expenses necessary to cure, give relief, or reduce the degree or the period of a covered condition. When your claim is accepted, a DEEOIC Medical Benefits Examiner (MBE) assigned to your case will work closely with you to ensure proper adjudication of medical benefits under EEOICPA.

COVERED MEDICAL CONDITIONS

WHEN DOES DEEOIC BEGIN COVERING MEDICAL CONDITIONS?

The EEOICPA provides medical benefits for medical condition(s) accepted in a claim from the day a person files a claim for those conditions.

In addition to an accepted condition, the EEOICPA will cover any consequential illness incurred as a result of an accepted condition. A consequential illness is a new and separate medical problem that a doctor identifies as having developed due to the original accepted illness. To file a consequential illness, please contact your local Resource Center (Contact information below).

MEDICAL BENEFITS

WHAT TYPE OF MEDICAL BENEFITS ARE COVERED?

Medical benefits for covered illnesses include reasonable and customary medical care, physician prescribed medications, and travel directly associated with the treatment of a covered illness. The following is a list of some of the services that are covered:

- Doctor's office visits, medical treatments, and consultations.
- Inpatient and outpatient hospital charges, including emergency room visits.
- Durable medical equipment.
- Diagnostic laboratory and radiological testing.
- Drugs prescribed by a physician, both brand-named and generic.
- Ambulance services.
- Home and Residential Health Care.
- Travel to the doctor, hospital, clinic, or other medical facility.

MEDICAL BILL PAYMENTS

WHO IS THE PRIMARY PAYER FOR MY ACCEPTED MEDICAL CONDITION?

DEEOIC is the primary payer for all care linked to an accepted illness. Being a primary payer means DEEOIC is responsible for covering the cost of treatment of your accepted illness. However, you must submit costs linked to care unrelated to an accepted illness (i.e., any non-covered condition) to other forms of medical coverage you may possess, i.e., to your private insurance or to other government health programs such as Medicare or Medicaid.

DEEOIC pays costs associated with the treatment of an accepted medical condition from the EEOICPA compensation fund and these costs are subject to a fee schedule. A fee schedule is an agreement under which a provider agrees to accept a payment for a medical service at a set rate. For your coverage, DEEOIC does not require you to pay a co-payment or deductible.

HOW WILL DEEOIC PAY MY MEDICAL BILLS?

Providers, claimants, and DEEOIC staff are to send medical bills, bill attachments, treatment notes, and requests for claimant reimbursement to the Medical Bill Processing Agent for scanning and keying into their system. Providers are to submit bills for covered medical services electronically or mail them to the DEEOIC Medical Bill Processing Agent at:

- Energy Employees Occupational Illness Compensation Program
  P.O. Box 8304
  London, KY 40742-8304

Any medical provider enrolled with DEEOIC will receive payment for services directly. If your physician or medical provider has not enrolled with DEEOIC, they may contact the DEEOIC Medical Bill Processing Agent or a Resource Center for enrollment information.

You may also pay for medical services out-of-pocket and then request reimbursement of your expenses.

HOW DO I LOCATE ENROLLED PROVIDERS?

A provider search feature is available on the Medical Bill Processing Agent's website at: http://owcpmed.dol.gov.

MEDICAL BENEFITS IDENTIFICATION CARD

WILL I RECEIVE A MEDICAL BENEFITS CARD?

Yes. Once DEEOIC awards you medical benefits, you will receive a DEEOIC Medical Benefits Identification Card (MBIC). The MBIC is imprinted with your Name, Case ID Number, Benefits Identification Number (BIN), DEEOIC Group ID Number, and the Department of Labor logo. The back of the card includes the address to submit bills, and the toll-free customer service numbers that you or your provider can call to address any billing questions. The back of the card also identifies the Medical Bill Processing Website: http://owcpmed.dol.gov.

Present the card to your doctor at the time of treatment for your accepted condition(s). If your card is lost or destroyed, call DEEOIC's Medical Bill Processing Agent toll-free at (866) 272-2682 to ask for a replacement card.

DEEOIC RESOURCE CENTERS

HOW DO I CONTACT A RESOURCE CENTER?

DEEOIC has 11 Resource Centers nationwide to assist employees and their families. If you need help with medical benefits or the medical billing process, contact the Resource Center nearest you. Resource Center staff can provide assistance in person or over the telephone.

California Resource Center
7027 Dublin Blvd., Suite 150
Dublin, California 94568
Telephone: (925) 606-6302
Fax: (925) 606-6303
Toll Free: (866) 606-6302
California, Hawaii

New York Resource Center
6000 North Bailey Avenue
Suite 2A, Box #2
Amherst, New York 14226
Telephone: (716) 832-6200
Fax: (716) 832-6638
Toll Free: (800) 941-3943
Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

Denver Resource Center
8758 Wolff Court, Suite 101
Westminster, Colorado 80031
Telephone: (720) 540-4977
Fax: (720) 540-4976
Toll Free: (866) 540-4977
Colorado, Iowa, Kansas, Nebraska, Oklahoma, Wyoming

Espanola Resource Center
412 Paseo De Onate, Suite "D"
Espanola, NM 87532
Telephone: (505) 747-6766
Fax: (505) 747-6765
Toll Free: (866) 272-3622
New Mexico, Texas

Hanford Resource Center
303 Bradley Blvd., Suite 206
Richland, WA 99352
Telephone: (509) 946-3333
Fax: (509) 946-2009
Toll Free: (888) 654-0014
Alaska, Oregon, Washington

Idaho Resource Center
Exchange Plaza
1820 East 17th Street, Suite 250
Idaho Falls, ID 83404
Telephone: (208) 523-0158
Fax: (208) 557-0551
Toll Free: (800) 861-8608
Idaho, Montana, North Dakota, South Dakota, Utah

Las Vegas Resource Center
Flamingo Grand Plaza
1050 East Flamingo Road, Suite W-156
Las Vegas, NV 89119
Telephone: (702) 697-0841
Fax: (702) 697-0843
Toll Free: (866) 697-0841
Nevada, Arizona

Oak Ridge Resource Center
Jackson Plaza Office Complex
800 Oak Ridge Turnpike, Suite C-103
Oak Ridge, TN 37830
Telephone: (865) 481-0411
Fax: (865) 481-8832
Toll Free: (866) 481-0411
Alabama, Arkansas, Louisiana, Mississippi, Tennessee, Virginia

Paducah Resource Center
Barkley Center
125 Memorial Center
Paducah, KY 42001
Telephone: (270) 534-0599
Fax: (270) 534-8723
Toll Free: (866) 534-0599
Illinois, Indiana, Kentucky, Missouri

Portsmouth Resource Center
3612 Rhodes Ave
New Boston, OH 45662-4935
Telephone: (740) 353-6993
Fax: (740) 353-4707
Toll Free: (866) 363-6993
Ohio, Michigan, Minnesota, Puerto Rico, West Virginia, Wisconsin

Savannah River Resource Center
1708-B Bunting Drive
North Augusta, SC 29841
Telephone: (803) 279-2728
Fax: (803) 279-0146
Toll Free: (866) 666-4606
Florida, Georgia, North Carolina, South Carolina

PRE-APPROVAL MAY BE REQUIRED FOR SOME MEDICAL EXPENSES

WHEN SHOULD I REQUEST PRE-APPROVAL OF A MEDICAL EXPENSE?

The following expenses require review and approval by your Medical Benefits Examiner (MBE) ***before*** you or your provider submit a reimbursement request or a bill.

- Overnight travel for medical treatment of the accepted condition(s) (each occurrence)
- Travel for medical treatment of the accepted condition(s) if the mileage exceeds 200 miles round trip (each occurrence)
- Companion travel to a medical appointment
- Home health care services (in-home nursing)
- Rehabilitative Therapy
    - Physical Therapy
    - Occupational Therapy
    - Speech Therapy
- Nursing home or assisted living facility
- Hospice care
- Psychiatric treatment
- Chiropractic treatment
- Acupuncture treatment
- Special equipment as prescribed by your treating physician
- Durable medical equipment
- Any health or gym facility membership
- Home exercise equipment
- Home renovations
- Automobile modifications
- Organ or stem cell transplants
- Medical documentation retrieval

Your assigned MBE reviews requests for these services to establish medical necessity in treating or relieving the effects of your accepted work related illness. In most cases, the MBE will work directly with you and your doctor to obtain the information necessary to authorize a request for these services.

INITIAL REQUESTS FOR HOME HEALTH CARE, NURSING HOME, OR ASSISTED LIVING REQUIRE SUBMISSION OF FORMS EE-17A and EE-17B

WHAT IS THE PROCESS IF I AM REQUESTING HOME HEALTH CARE, NURSING HOME, OR ASSISTED LIVING FOR THE FIRST TIME?

If you are requesting Home Health Care, Nursing Home, or Assisted Living benefits directly related to your DEEOIC accepted condition(s) and ordered by your treating physician, you must submit *Form EE-17A* to your Medical Benefits Examiner, and your treating physician must submit *Form EE-17B* along with documentation in support of your request for these benefits. For assistance, please contact your local Resource Center. The forms are available online at:

https://www.dol.gov/owcp/energy/regs/compliance/EEOICPForms/ee-17a.pdf
https://www.dol.gov/owcp/energy/regs/compliance/EEOICPForms/ee-17b.pdf

REIMBURSEMENT OF MEDICAL EXPENSES

HOW DOES DEEOIC REIMBURSE FOR OUT-OF-POCKET MEDICAL EXPENSES FOR COVERED MEDICAL CARE?

To obtain reimbursement for out-of-pocket medical expenses for covered medical care, complete Form OWCP-915, *Claim for Medical Reimbursement.* The form is available online at: https://www.dol.gov/owcp/dfec/regs/compliance/OWCP-915.pdf In addition, you must submit the following items, which are to be attached securely to the form:

- A copy of your provider's itemized billing statement to include a description of services and clear receipt of payment.
- Evidence of your method of payment. Acceptable evidence of payment includes a cash receipt, copy of your cancelled check (both front and back), or a copy of your credit card receipt.

You may include up to eight (8) visits or services on a single form for reimbursement, as long as you receive services by the same medical provider. You must be sure to complete each entry on the form completely. If you have receipts, you may mark the entry, "See Attached" and then submit the receipts with the form.

When seeking reimbursement involving multiple providers, you must complete a separate form for each medical provider.

Mail the completed Claim for Medical Reimbursement form, with attachments, to the Medical Bill Processing Agent at:

- Energy Employees Occupational Illness Compensation Program
  P.O. Box 8304
  London, KY 40742-8304

SHOULD I KEEP COPIES OF THE BILLS I SUBMIT?

Yes. Always keep copies of your bills and receipts submitted so that you have a record of your reimbursement request(s).

TIME LIMITS

ARE THERE TIME LIMITS FOR THE SUBMISSION OF MEDICAL BILLS OR REQUESTS FOR REIMBURSEMENT?

Yes. You must submit bills no more than one year beyond the end of the calendar year in which the expense was incurred, or the service or supply was provided; or, more than one year beyond the end of the calendar year in which DEEOIC first accepted the claim, whichever is later. DEEOIC pays providers and reimburses employees promptly for all bills that are properly submitted on an approved form and which are submitted in a timely manner.

You should submit requests for reimbursement by the end of the calendar year after the year when the expenses were incurred. For example, if you incurred expenses in 2019, submit your request no later than December 31, 2020.

PRESCRIPTION BENEFITS

WHAT MEDICATIONS ARE COVERED?

DEEOIC will pay for medications that your doctor prescribes to treat an accepted condition. To verify that a medication is payable for treating your accepted condition, you or your pharmacist may call the Pharmacy Bill Processing Agent toll-free at (866) 664-5581. You will need the 11-digit National Drug Code (NDC) for each medication; you can obtain the NDC from your pharmacist.

HOW DOES THE PHARMACY BILL DEEOIC FOR MY COVERED PRESCRIPTIONS?

If you have any questions regarding how the pharmacy will bill for your prescriptions, you may call the pharmacy helpdesk toll-free at (866) 664-5581.

WHAT IF MY PHARMACY IS NOT ENROLLED WITH DEEOIC?

If DEEOIC does not have your pharmacy enrolled, you may pay for your prescription(s) out-of-pocket and then submit a request for reimbursement using Form OWCP-915, *Claim for Medical Reimbursement*.

REIMBURSEMENT OF PRESCRIPTION EXPENSES

HOW DO I GET REIMBURSED FOR OUT-OF-POCKET EXPENSES FOR COVERED PRESCRIPTIONS?

To obtain reimbursement for covered prescriptions, complete Form OWCP-915, *Claim for Medical Reimbursement*. Up to eight prescriptions can be listed on one form if purchased from the same pharmacy. If you use more than one pharmacy, submit a separate form for each pharmacy. Each entry on the form must be filled in completely. If you need help obtaining or completing this form, you may contact one of the Resource Centers.

In addition to submitting Form OWCP-915, you must submit original pharmacy receipts which are to be attached securely to the form. Acceptable receipts include any of the following:

- Pharmacy bag or sticker containing the payment information for each prescription
- Itemized bill or computer printout of your bill, which includes a clear description of services and/or each drug prescribed
- Itemized listing of your prescriptions and costs on pharmacy's letterhead

NOTE: A self-written itemized list or cash register receipt is **not** considered proof of payment.

To allow reimbursement, DEEOIC must have the following information

- Your full name and address
- Date prescription was filled
- Prescription number
- Name of prescribing doctor
- Name and address of pharmacy
- Name of each prescription drug
- 11-digit National Drug Code (NDC) number for each prescribed medicine
- Dosage prescribed such as mg per pill or ml or cc per measurement
- Total number of pills or liquid amount per bottle prescribed (quantity)
- Charge actually paid for each drug, after any discount is applied (e.g., senior citizen discount, coupon, or pharmacy transfer incentive)
- Statement marked "patient paid" or "paid by patient" showing who paid the charge. "Paid" or "Paid in Full" are ***not acceptable.***

Reimbursement for of out-of-pocket expenses may be subject to an established list of maximum dollar allowances for medical services.

REIMBURSEMENT OF TRAVEL EXPENSES FOR MEDICAL TREATMENT

HOW DO I OBTAIN REIMBURSEMENT FOR THE COST OF TRAVEL FOR MEDICAL TREATMENT?

If you must travel to obtain medical treatment, DEEOIC will reimburse you for mileage. The reimbursement rate for mileage is based on the rate established by the General Services Administration (GSA) and can be found on their website at www.gsa.gov. If you travel by privately owned vehicle (POV) in a single day and do not exceed 200 miles roundtrip, authorization for travel ***prior to travel*** is not required.

Overnight travel, any travel other than by POV, and POV travel that exceeds 200 miles round-trip requires authorization from your Medical Benefits Examiner *prior to travel*. Additionally, if a travel companion is required, you must obtain authorization from your Medical Benefits Examiner *prior to travel*. Upon authorization, which may cover multiple trips, DEEOIC will send you an approval letter and further information.

DEEOIC can reimburse overnight travel, lodging, plus meals and incidental expenses (M&IE) according to the federal government per diem rate, which is based on the travel location. The per diem rates can be found on the GSA website at www.gsa.gov. Reimbursement for lodging will not exceed the daily federal government per diem rate.

The reimbursement for M&IE is based on a daily, flat-rate allowance for each day of authorized travel. The first and last days of travel are reimbursed at 75% of the M&IE allowance. If DEEOIC approves your companion travel request, we will also pay an additional daily allowance for your travel companion.

Local transportation costs, such as taxis, airport shuttles, or bus fares are reimbursable separately from the M&IE allowance. Services such as airport or hotel courtesy shuttles should be used when available.

To obtain reimbursement for covered travel expenses, complete Form OWCP-957, *Medical Travel Refund Request*. The form is available online at: https://www.dol.gov/owcp/dfec/regs/compliance/OWCP-957.pdf. You can list up to three single days of travel on each form. You must submit lodging receipts and receipts for reimbursement of any allowable expense of $75 or more with your travel reimbursement request. Receipts are always required, regardless of amount, for lodging, airfare, rental cars, and gasoline purchases for rental cars. Mail the completed *Medical Travel Refund Request*, with the required receipts securely attached to the form, to the Medical Bill Processing Agent at:
Energy Employees Occupational Illness Compensation Program
P.O. Box 8304
London, KY 40742-8304

PROCESSING A REQUEST FOR REIMBURSEMENT

HOW LONG DOES IT TAKE TO PROCESS A REIMBURSEMENT REQUEST?

DEEOIC will process a properly completed reimbursement request within thirty (30) days after it is received.

WILL I BE NOTIFIED IF MY REIMBURSEMENT REQUEST IS NOT COMPLETED CORRECTLY?

Yes. If a reimbursement request form needs your correction or DEEOIC requires additional information, the Medical Bill Processing Agent will contact you by telephone. If attempts to reach you by telephone are not successful, the form and receipts will be returned to you with a letter of explanation. It is important that you make the required corrections and return these materials as soon as possible. Mail the corrected reimbursement request forms, with receipts securely attached, to the Medical Bill Processing Agent at:

- Energy Employees Occupational Illness Compensation Program
  P.O. Box 8304
  London, KY 40742-8304

If you need assistance with completing the reimbursement request, contact one of the DEEOIC Resource Centers.

HOW WILL I KNOW IF MY REIMBURSEMENT REQUEST HAS BEEN PAID?

You will receive a Remittance Voucher (RV) by mail that will notify you once DEEOIC has processed your reimbursement for payment. A Remittance Voucher will contain the following information:

- Remittance Voucher number (RV No.)
- Reference number
- Date paid
- Description and amount of your reimbursement request
- Amount you will be paid

NOTE: You will not receive a Remittance Voucher if your medical provider directly billed the Department of Labor.

If you have a question about a Remittance Voucher or a reimbursement amount, please contact a Resource Center or the DEEOIC Medical Bill Processing Agent.

HOW IS MY REIMBURSEMENT PAYMENT MADE?

Reimbursement for out-of-pocket expenses, such as qualified medical bills and medical travel expenses, is payable via paper check. A check will be issued by the U.S. Department of the Treasury and mailed separately from the Remittance Voucher. You should receive the check within fourteen (14) days after you receive the Remittance Voucher. In accordance with Department of the Treasury regulations, individuals requesting payment by check can only be approved under limited circumstances, and upon written request from the payee.

Electronic Funds Transfer (EFT) is offered as the preferred payment method. EFT is available for deposit directly into your checking or savings account. EFT is a much faster and more secure way to receive reimbursement compared to paper checks. DEEOIC strongly encourages beneficiaries to select EFT as the preferred payment method. To obtain the *Direct Deposit Sign-Up Form 1199A* go online to: https://www.dol.gov/owcp/energy/regs/compliance/EEOICPForms/SF1199A.pdf.

WHAT HAPPENS IF MY REIMBURSEMENT REQUEST IS DENIED?

If DEEOIC has to deny a reimbursement, it will provide an explanation of benefits at the bottom of the Remittance Voucher sent to you and it will explain why DEEOIC had to reject any portion of the reimbursement request.

MEDICAL BENEFITS FOR CLAIMS FILED BY SURVIVORS

ARE COVERED SURVIVORS ENTITLED TO MEDICAL BENEFITS?

In an *accepted claim filed by a survivor*, where the claim was *originally filed by the employee*, medical benefits can be awarded for the accepted condition(s) for medical expenses incurred by the employee from the date the employee filed the claim to the date of death of the employee.

In this scenario, a survivor may file a request for reimbursement of out-of-pocket expenses incurred by the employee for medical treatment and prescriptions for the accepted illness. Submit Form OWCP-915, *Claim for Medical Reimbursement*, along with the appropriate documentation. DEEOIC will then issue payment to the estate of the deceased employee.

WILL THE OUTSTANDING MEDICAL EXPENSES BE PAID TO A MEDICAL PROVIDER?

If a medical expense for treatment of an accepted illness(s) was incurred during the covered period, and it remains outstanding with a medical provider who is enrolled in the program, the medical provider may submit the bill for payment to the Medical Bill Processing Agent. To be considered for payment, bills and requests for reimbursement must be submitted by the end of the calendar year after the year when the claim was first accepted as compensable by the Department of Labor.

CONTACT INFORMATION

HOW DO I CONTACT THE BILL PROCESSING AGENT?

MEDICAL BILL PROCESSING AGENT

Mailing address:
Energy Employees Occupational Illness Compensation Program
P.O. Box 8304
London, KY 40742-8304

Toll-free telephone number: (866) 272-2682
Customer Service Agents are available Monday-Friday, 8:00 a.m. to 8:00 p.m. (ET)

Website: http://owcpmed.dol.gov

PHARMACY BILL PROCESSING AGENT

Mailing address:
Department of Labor Pharmacy Bill Processing, DEEOIC
P.O. Box 8310
London, KY 40742-8310

Toll-free telephone number: (866) 664-5581
Customer Service Agents are available Monday-Friday, 8:00 a.m. to 8:00 p.m. (ET)

Website: http://owcprx.dol.gov

IF I CHANGE MY MAILING ADDRESS, WHO SHOULD I NOTIFY?

Any changes in your mailing address must be reported in writing to the following address:

- U.S. Department of Labor
  DEEOIC Central Mailroom
  P.O. Box 8306
  London, KY 40742-8306

You may also upload change-of-address information directly to the Energy Document Portal at: https://eclaimant.dol-esa.gov.

ATTACHMENTS

- Sample EEOICP Medical Identification Card
- Sample Medical Reimbursement Form - OWCP-915 (Office Visit)
- Sample Medical Reimbursement Form - OWCP-915 (Prescriptions)
- Sample Pharmacy Receipt & Proof of Payment
- Sample Medical Travel Refund Request Form - OWCP-957
- Sample Remittance Voucher
- Sample How to Read Your Remittance Voucher

Sample DEEOIC Medical Identification Card

Front

US Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

Medical Benefits Identification Card

John Doe

Case Number: 1234567890
Pharmacy BIN: 610084
DEEOIC Group ID #: OWCP1222

No Co-Pay/No Deductible

MISUSE OF CARD IS PUNISHABLE BY LAW

Back

1. This card is the property of the U.S. Government and its counterfeiting, alteration or misuse is a violation of Section 499, Title 18, U.S. Code.
2. Carry the card with you at all times and show it to your doctor, clinic, pharmacist or hospital when you are in need of medical services for your accepted condition(s).
3. Medical treatment authorized under the Energy Employees Occupational Illness Compensation Program Act is paid for by the U.S. Department of Labor. Call toll free (866)-272-2682 for specific information related to medical services. Call toll free (866)-664-5581 for specific information related to pharmacy services.
4. All bills should be submitted to the U.S. Department of Labor OWCP/DEEOIC , P.O. Box 8304, London, KY 40742-8304.
5. If found, drop in mailbox. Postage guaranteed. Return to: U.S. Department of Labor OWCP/DEEOIC , P.O. Box 8306, London, KY 40742-8306.
6. When using the DOL OWCP website **(http://owcpmed.dol.gov)** to request an authorization for medical services or to verify eligibility, your doctor must use the Case Number located on the front of the card. Claimants can also use the Case Number to access the DOL OWCP website.

Sample Medical Reimbursement Form (OWCP-915) – Office Visit

Claim for Medical Reimbursement

Reset | Print

U.S Department of Labor
Office of Workers' Compensation Programs

Provide all information requested below. **DO NOT FILL IN SHADED AREAS.** Read the attached information in order to ensure the submission of all required documentation. Maintain a copy of all documentation for your records.

OMB No. 1240-0007
Expires: 06/30/2021

PERSONAL INFORMATION

Name			OWCP File Number
Smith	John	A	123-45-6789
Last	First	M.I.	

Address			Telephone Number
1234 Main St			(000) 123-4567
Street/P.O. Box/Apt No.			FOR DOL USE ONLY
Tunnelsport		16600	
City	State	Zip Code	

PROVIDER INFORMATION

Name of Doctor's Office, Hospital, Pharmacy or Medical Supply Company where expense was incurred. (A separate OWCP-915 must be filed for each provider) Enter Doctor's Name

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM/DD/YYYY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
Office Visit	11/11/2014	11/11/2014	$65.00	☒	☐
Office Visit	12/22/2014	12/22/2014	$65.00	☒	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Total Reimbursement
$130.00

I certify that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered condition. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain reimbursement from OWCP is subject to civil penalties and/or criminal prosecution.

I authorize any provider named above to release information to the US Department of Labor, OWCP if necessary for the proper adjudication of this claim.

Signature John Smith Date 2/10/2015

OWCP-915 (Rev. 12-07)

Sample Medical Reimbursement Form (OWCP-915) – Prescriptions

Claim for Medical Reimbursement

U.S Department of Labor
Office of Workers' Compensation Programs

Provide all information requested below. **DO NOT FILL IN SHADED AREAS.** Read the attached information in order to ensure the submission of all required documentation. Maintain a copy of all documentation for your records.

OMB No. 1240-0007
Expires: 01/31/2016

PERSONAL INFORMATION

Name			OWCP File Number
Smith	John	A	123-45-6789
Last	First	M.I.	
Address			Telephone Number
1234 Main Avenue			(000) 123-4567
Street/P.O. Box/Apt No.			FOR DOL USE ONLY
Tunnelsport	PA	16600	
City	State	Zip Code	

PROVIDER INFORMATION

Name of Doctor's Office, Hospital, Pharmacy or Medical Supply Company where expense was incurred. (A separate OWCP-915 must be filed for each provider)

DRUG STORE NAME

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM/DD/YYYY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
TETRACYCLINE NDC 00182-0112-01	07/15/2014	07/15/2014	$45.00	[x]	[ ]
THEODUR NDC 00085-0487-01	04/23/2014	04/23/2014	$85.65	[x]	[ ]
				[ ]	[ ]
				[ ]	[ ]
				[ ]	[ ]
				[ ]	[ ]
				[ ]	[ ]
				[ ]	[ ]

Total Reimbursement
$130.65

I certify that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered condition. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain reimbursement from OWCP is subject to civil penalties and/or criminal prosecution.

I authorize any provider named above to release information to the US Department of Labor, OWCP if necessary for the proper adjudication of this claim.

Signature *John A. Smith* Date *08/16/2014*

OWCP-915 (Rev. 12-07)

Sample Pharmacy Receipt

Tunnelsport Drug
345 Main Street, Tunnelsport PA 16600
(814) 999-0123

Smith, Charles
319 Jefferson Drive
Tunnelsport, PA 16600
999-99-9999

Date: 04/15/2015
Dr. J. C. Wazab

RX 9166, Refill 1 time, 15 days
Lasix 20MG Tab SA
NDC: 00039-0067-10
QTY: 15

Patient Paid RPh
$7.99

Thank you very much!

Sample Pharmacy Proof of Payment

Profile Print
Insurance Print
Tunnelsport Drug Store
345 Main Street
Tunnelsport, PA 16600

For

Smith, Charles P.
319 Jefferson Drive
Tunnelsport, PA 16600
999-99-9999

RX# 105221	Tetracycline 250 MG	DATE	QTY	PRICE	RPH
	Doctor: J. Wazab	5/18/15	90	$6.04	ED
PATIENT PAID					
	00182-0112-01				
RX# 105221	Theo dur 100 MG TABS	8/1/2015	100	$15.82	ED
PATIENT PAID					

NOTE: PHARMACIST SIGNATURE REQUIRED

Sample Travel Refund Request Form (OWCP-957)

Medical Travel Refund Request

Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs

NOTE: This report is authorized by the Federal Employees' Compensation Act (5 USC 8103(a)), the Black Lung Benefits Act (30 USC 901, 20 CFR 725.406 and 725.701) and the Energy Employees Occupational Illness Compensation Program Act of 2000, (42 USC 7384 and 20 CFR 30.701). While you are not required to respond, this information is required to obtain reimbursement for travel expenses. The method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974 and OMB Circ. 130. This form should be used for medically related travel covered by the Federal Employees' Compensation Act, the Black Lung Benefits Act and the Energy Employees Occupational Illness Compensation Program Act of 2000.

OMB No. 1240-0037
Expires: 06/30/2021

1. Claimant's Name (Last, First, MI.): Smith | John | A

2. Case/Claim Number: 123456789

3. Payee's Name if different from claimant's name (last, first, mi.): (See Instruction No. 3 for further requirements if payee is not the claimant)

4. Claimant's/Payee's Address (Street/RFD, City, State, Zip Code. See Instruction No. 4 for address requirements if claim is filed under the Division of Federal Employees' Compensation): 1234 Main Avenue | Tunnelsport | PA | 16600

Special Instructions: 1. See reverse side of form for complete instructions and attachment of receipts.
2. Physician's signature or facsimile is **REQUIRED by BLACK LUNG** for verification of each service date and type.

5a. Date of Travel: 04/12/2015

b. [ ] One-way [X] Round Trip

c. Travel From: [ ] Hospital [ ] Office/clinic [ ] Lab [X] Home

d. Travel To: [ ] Hospital [X] Office/clinic [ ] Lab [ ] Home

e. Medical Facility Name and Address: Tunnel Sport Clinic, 156 Crain Lane, Tunnel sport, PA 16600

f. Total expense/cost
- [ ] Taxi $
- [ ] Bus/Train
- [X] Tolls/Pkg 2.50
- [ ] Lodging
- [ ] Meals
- [ ] Other (Specify)

g. Private Auto Only Miles traveled: 15

DOL USE ONLY
TOS/Prooedure Code | $
Total $

FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only) Care Rendered
- [ ] Treatment for Black Lung
- [ ] Not Black Lung Related
- [ ] Determine, Test for Black Lung

Diagnosis
(Signature of Physician)
(Date Care Rendered)

6a. Date of Travel:

b. [ ] One-way [ ] Round Trip

c. Travel From: [ ] Hospital [ ] Office/clinic [ ] Lab [ ] Home

d. Travel To: [ ] Hospital [ ] Office/clinic [ ] Lab [ ] Home

e. Medical Facility Name and Address: Tunnel Sport Clinic, 156 Crain Lane, Tunnel sport, PA 16600

f. Total expense/cost
- [ ] Taxi $
- [ ] Bus/Train
- [X] Tolls/Pkg 2.50
- [ ] Lodging
- [ ] Meals
- [ ] Other (Specify)

g. Private Auto Only Miles traveled: 15

DOL USE ONLY
TOS/Prooedure Code | $
Total $

FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only) Care Rendered
- [ ] Treatment for Black Lung
- [ ] Not Black Lung Related
- [ ] Determine, Test for Black Lung

Diagnosis
(Signature of Physician)
(Date Care Rendered)

7a. Date of Travel:

b. [ ] One-way [ ] Round Trip

c. Travel From: [ ] Hospital [ ] Office/clinic [ ] Lab [ ] Home

d. Travel To: [ ] Hospital [ ] Office/clinic [ ] Lab [ ] Home

e. Medical Facility Name and Address

f. Total expense/cost
- [ ] Taxi $
- [ ] Bus/Train
- [ ] Tolls/Pkg
- [ ] Lodging
- [ ] Meals
- [ ] Other (Specify)

g. Private Auto Only Miles traveled

DOL USE ONLY
TOS/Prooedure Code | $
Total $

FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only) Care Rendered
- [ ] Treatment for Black Lung
- [ ] Not Black Lung Related
- [ ] Determine, Test for Black Lung

Diagnosis
(Signature of Physician)
(Date Care Rendered)

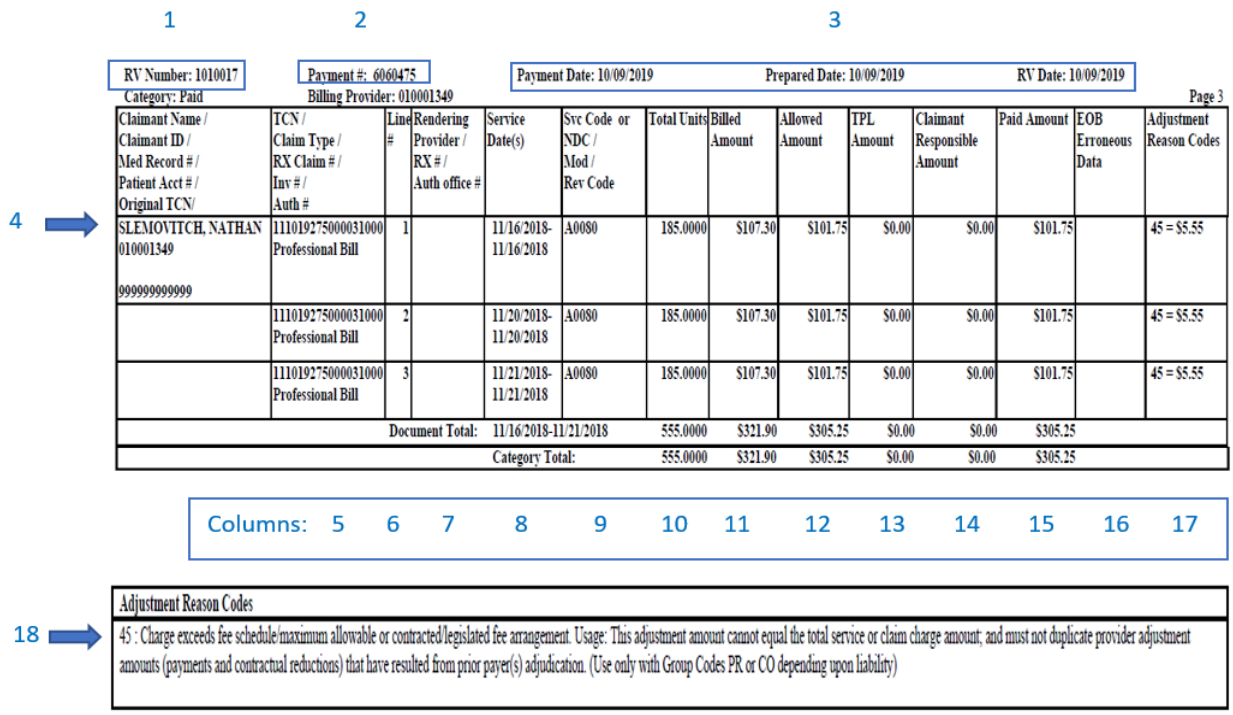
8. **Payee's Certification:** I certify that the information provided is true and accurate to the best of my knowledge and belief. I am aware that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain reimbursement as provided by the OWCP, or who knowingly accepts reimbursement to which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for OWCP fraud will result in termination of all current and future OWCP benefits.

Claimant's/Payee's Signature: John Smith Date: 07/01/2015

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for REQUESTS FOR ACCOMMODATIONS OR AUXILIARY AIDS AND SERVICES.

Form OWCP-957
Revised February 2017

SAMPLE REMITTANCE VOUCHER



1 2 3

RV Number: 1010017 | Payment #: 6060475 | Payment Date: 10/09/2019 | Prepared Date: 10/09/2019 | RV Date: 10/09/2019

Category: Paid | Billing Provider: 010001349 | Page 3

Claimant Name / Claimant ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev Code	Total Units	Billed Amount	Allowed Amount	TPL Amount	Claimant Responsible Amount	Paid Amount	EOB Erroneous Data	Adjustment Reason Codes
4 → SLEMOVITCH, NATHAN 010001349 999999999999	11101927500003100 Professional Bill	1		11/16/2018-11/16/2018	A0080	185.0000	$107.30	$101.75	$0.00	$0.00	$101.75		45 = $5.55
	11101927500003100 Professional Bill	2		11/20/2018-11/20/2018	A0080	185.0000	$107.30	$101.75	$0.00	$0.00	$101.75		45 = $5.55
	11101927500003100 Professional Bill	3		11/21/2018-11/21/2018	A0080	185.0000	$107.30	$101.75	$0.00	$0.00	$101.75		45 = $5.55
			Document Total:	11/16/2018-11/21/2018		555.0000	$321.90	$305.25	$0.00	$0.00	$305.25		
				Category Total:		555.0000	$321.90	$305.25	$0.00	$0.00	$305.25		

Columns: 5 6 7 8 9 10 11 12 13 14 15 16 17

Adjustment Reason Codes
18 → 45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)

1. Each Remittance Voucher (RV) created has its own unique number and it will appear on any checks sent by DOL.
2. When you receive a check, this reference number will be printed on it. This will help you match the check to the RV.
3. Shows the date of payment and when the RV was prepared and issued.
4. Displays the claimants name, claimant ID, medical record ID, patient account # and the original TCN (if bill was adjusted) for the bill.

Columns

5. Displays the current TCN, type of bill, and authorization number applied to the bill.
6. List the individual line numbers from your bill.
7. Does not apply to claimants' RVs.
8. The date services were rendered to you.
9. The procedure code that represents what services are being rendered.
10. Units billed.
11. Line item billed amounts.
12. Allowed amount.
13. Third Party Liability amount if present on the bill.
14. Claimant Responsibility- claimants do not have out of pocket expenses, unless there was an overpayment.
15. The amount paid to the claimant.
16. Explanation of Benefits reason codes, representing errors/denials on the bill.
17. Adjustment reason codes- representing any adjustments that were made to the bill
18. Explanation of any reason codes reported on bill.