Claimant Reimbursement Forms

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Obtaining a Claimant Reimbursement Form

1. **Go to http//owcpmed.dol.gov**
2. Click Resources
3. Click Forms & References

Office of Workers' Compensation Programs
Medical Bill Processing Portal

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ATTENTION: Moving Toward a Fully-Electronic Medical Bill Processing System

COVID-19 Update

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Obtaining a Claimant Reimbursement Form

4 **Under Claimant Reimbursement, select Claimant Medical/Pharmacy Reimbursement (OWCP 915) or Medical Travel Refund Request (OWCP 957)**

Forms and References

General | DCMWC | DEEOIC | DFEC | DLHWC

General Administrative Forms & References

Note: For program specific forms, please click the respective program link above.

Claimant Reimbursement

Claimant Medical Reimbursement (OWCP-915)

Medical Travel Refund Request (OWCP-957)

Provider Enrollment

Provider Enrollment Application (OWCP-1168)

EDI Enrollment Template (For Billing Agent/Clearinghouse Only)

EFT Form | (Instructions)

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OWCP 915 Medical Reimbursement

Instructions for use of FORM OWCP-915 Medical Reimbursement

- The OWCP-915 is used to seek reimbursement for out-of-pocket medical expenses pertaining to the treatment of an accepted condition including (but not limited to) medical treatments, prescription medications and medical supplies.
- Please submit a separate reimbursement form for each provider where an out of pocket expense was incurred.
- Please print clearly and legibly. Reference your OWCP Case ID on all documentation.
- Maintain a copy of the completed OWCP-915 and supporting documentation for your records

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Completing the OWCP 915 Medical Reimbursement form

1

Enter your personal information

Note: Do not enter information in the gray shaded areas

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

Last First M.I.

OWCP File Number

Address

Street/P.O. Box/Apt No.

City State Zip Code

Telephone Number

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Completing the OWCP 915 Medical Reimbursement form

2

Please list the Provider/Organization name.

Note: Claimants must submit a separate form for each Provider where Medical Services were rendered.

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)

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Completing the OWCP 915 Medical Reimbursement form

3

- List the description of charges
- Enter the Date of Service (MM/DD/YYYY) range
- Enter the Amount paid out of pocket by Claimant
- Select "YES" checkbox stating that you have included Proof of Payment
- Up to 8 visits and/or services can be listed on the form
- Calculate the Total Amount Paid for all visits and fill in the box at the bottom

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
				X	
				X	
			Total Reimbursement		

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Completing the OWCP 915 Medical Reimbursement form

Form must be signed by the Claimant

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 ______________________________ Date ______________

4

Form must be signed by claimant or a representative

5

A date is required and must be on or after the last date of service listed on this form.

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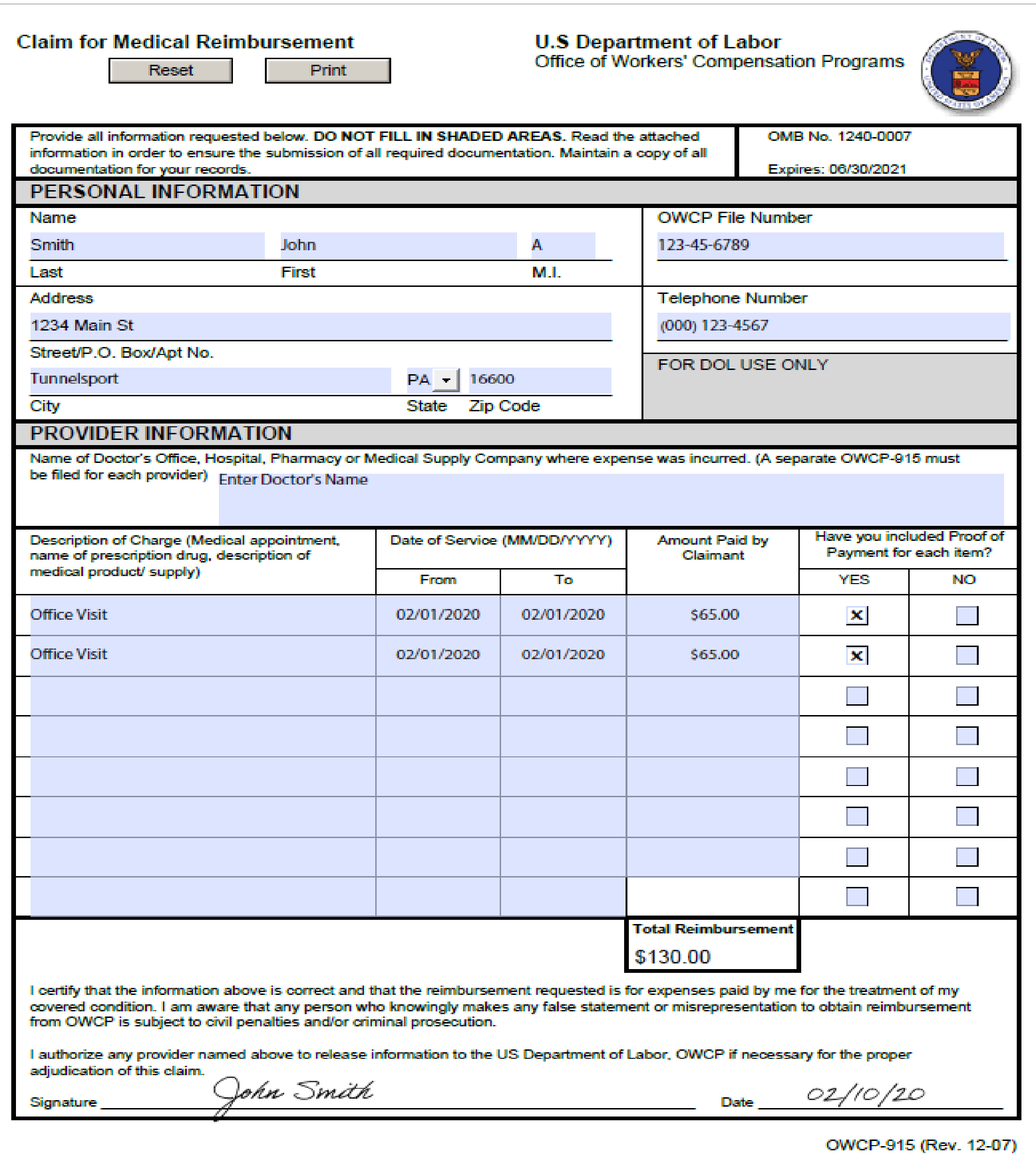
Completed 915 Form

1. Proof of payment is required (This can be a cash receipt, cancelled check or credit card slip)

2. It is recommended (but not required) to have your provider complete a medical, dental, or facility reimbursement form. The HCFA 1500 form is a good example. These forms can be submitted along with your 915 form to ensure your bill is coded correctly and you are reimbursed for the proper services.



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: Smith (Last) John (First) A (M.I.)

OWCP File Number: 123-45-6789

Address: 1234 Main St (Street/P.O. Box/Apt No.)

Telephone Number: (000) 123-4567

Tunnelsport (City) PA (State) 16600 (Zip Code)

FOR DOL USE ONLY

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) From	To	Amount Paid by Claimant	Have you included Proof of Payment for each item? YES	NO
Office Visit	02/01/2020	02/01/2020	$65.00	☒	☐
Office Visit	02/01/2020	02/01/2020	$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 02/10/20

OWCP-915 (Rev. 12-07)

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OWCP 915 Medical Reimbursement - Prescriptions

Completing the OWCP 915 Medical Reimbursement-Prescriptions Form

1

Enter your personal information

Note: Do not enter information in the gray shaded areas

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

Last First M.I.

OWCP File Number

Address

Street/P.O. Box/Apt No.

City State Zip Code

Telephone Number

FOR DOL USE ONLY

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Completing the OWCP 915 Medical Reimbursement- Prescriptions Form

2 Please list the Pharmacy name

Note: A separate form is required for each Pharmacy where medications were dispensed.

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)

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Completing the OWCP 915 Medical Reimbursement form

3

- List the National Drug Code #, the Quantity (how many ml/mg) and the days of supply under “Description of Charge”
- Enter the Date of Service (MM/DD/YYYY) when the prescription was filled
- Enter the Amount Paid by Claimant
- Select the “YES” checkbox stating that you have included proof of payment
- Up to 8 visits and/or services can be listed on this form
- Calculate the Total Amount Paid for all services and fill in the box at the bottom

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
				☒	☐
				☒	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
			Total Reimbursement		

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Completing the OWCP 915 Medical Reimbursement form

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 ______________________ Date ____________

4

Form must be signed by claimant or a representative

5

A date is required and must be on or after the last date of service listed on 915.

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Completed 915 - Prescriptions Form

1. Proof of payment is required
(This can be a cash receipt, pharmacy itemized statement, cancelled check or credit card slip).

2. Receipts and pharmacy itemized statements must be marked "patient paid" or "paid by patient" to show who paid the charges

3. If pharmacy receipts have the NDC #, quantity and day of supply, the drug name can be listed on the 915 form.

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: Smith (Last) John (First) A (M.I.)

OWCP File Number: 123-45-6789

Address: 1234 Main St (Street/P.O. Box/Apt No.)

Telephone Number: (000) 123-4567

Tunnelsport (City) PA (State) 16600 (Zip Code)

FOR DOL USE ONLY

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 Drug Store Name

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM/DD/YYYY) From	Date of Service (MM/DD/YYYY) To	Amount Paid by Claimant	Have you included Proof of Payment for each item? YES	NO
Tetracycline NDC 00182-0112-01	02/01/2020	02/01/2020	$45.00	X	
Theodur NDC 00085-0487-01	02/01/2020	02/01/2020	$85.00	X	

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 *02/10/20*

OWCP-915 (Rev. 12-07)

OWCP 957 Travel Reimbursement

Completing the OWCP 957 Travel Reimbursement form

1

Enter your personal information

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.):

2. Case/Claim Number:

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):

Completing the OWCP 957 Travel Reimbursement form

5a. Enter the Date you traveled

5b. Select if your trip was One-way or Round Trip

- **One-way-** leaving to go to a destination without returning to the place you left
- **Round trip** - you depart from your original location "**A**," travel to your destination "**B**", and return back to **"A" (where you began).**

5c. and **5d.** Select where you traveled from and to

5.e Enter the name and full address of the medical facility.

Note: The medical facility name and address traveled to and/or from should always be listed, whether you are going to or leaving the facility.

5a. 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

Completing the OWCP 957 Travel Reimbursement form

5f. Select the expenses that you paid for during your travel and list the dollar amount.

Note: If "Other" option was selected, please list the actual cost and specify the type of expense on the "Specify" line.

5g. If you use your private automobile for travel, list the travel miles (to and/or from the medical facility).

Note: Claimants are reimbursed per mile and not based on a gas receipt. Miles should include only whole numbers and not decimals. For example; If you traveled 9.2 miles, enter 9 miles.

f. Total expense/cost

- Taxi $
- Bus/Train
- Tolls/Pkg
- Lodging
- Meals
- Other

(Specify)

g. Private Auto Only
Miles traveled

Do not complete below.
It is for DOL use only!!!

DOL USE ONLY
TOS/Procedure Code

$

Total $

Completing the OWCP 957 Travel Reimbursement form

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)

5h. For **BLNG Claimants Only**. This section is to be completed by the physician. Only one checkbox can be selected to describe the reason for services rendered.

- Treatment for Black Lung
- Not Black Lung Related
- Determine, Test for Black Lung

Physician must enter Diagnosis details to represent what the treatment is for, Sign and enter Date.

Completing the OWCP 957 Travel Reimbursement form

Use the same steps from section 5 to complete sections 6 and 7 as needed.

Note: Sections cannot be partially completed. Use a new section for each Date of Service (DOS).

The person claiming reimbursement must Sign and enter the date. The date must be on or after the last date of travel.

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: Date:

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

Requirements for Reimbursement of the OWCP 957 Form

Original receipts are required for lodging, airfare, rental car, and any other expense that exceeds $75.

Claimant’s last name and OWCP Claim Number should be listed on submitted attachments.
Keep a copy for your records.

Black Lung Claimants:

- Travel expenses for the miner are reimbursable
- Prior Authorization from the District Office is needed for lodging or travel exceeding 100 miles one way or 200 miles roundtrip.
- Travel to pick up medicine, equipment or supplies is not reimbursable

Energy Claimants:

- Prior Authorization from the District Office is needed for lodging or travel exceeding 100 miles one way or 200 miles roundtrip.
- Prior Authorization from the District Office is needed for reimbursement of companion travel.

DFEC Claimants:

- Prior Authorization from the District Office is needed for meals, lodging and travel exceeding 100 miles roundtrip.

You are ready to submit your claim!

Claimant Reimbursements can be submitted:

Via Mail

1. **Department of Labor**
   OWCP/DFEC
   PO Box 8300
   London, KY 40742-8300

2. **Department of Labor**
   OWCP/DEEOIC
   PO Box 8304
   London, KY 40742-8304

3. **Department of Labor**
   OWCP/DCMWC
   PO Box 8302
   London, KY 40742-8302

Note: If your bill is not processed within 28 days, please contact a Customer Service Specialist @ 844.493.1966

Thank you!

CNSI looks forward to being the new medical bill processing agent for the OWCP programs and working with each of you!

Email: CNSIOWCPOutreach@cns-inc.com

Call Center:

Division of Federal Employees' Compensation (DFEC) 1-844-493-1966

Division of Energy Employees Occupational Illness Compensation (DEEOIC) 1-866-272-2682

Division of Coal Mine Workers' Compensation (DCMWC) 1-800-638-7072

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