DEEOIC Medical Benefits:

Frequently Asked Questions about the Energy Employees Occupational Illness Compensation Program

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

The following material gives you basic information about your medical benefits, but it is neither intended to cover every possible exception or special case, nor have the effect of law or regulations. Additionally, this information applies only if the Energy Employees Occupational Illness Compensation Program is responsible for your medical benefits. If a private party, such as your employer or its insurance carrier, is responsible for your medical benefits, different procedures may apply. You may contact that private party directly or the District Office which handles your claim with questions about your medical benefits. STOP HEALTH CARE FRAUD. If you suspect any health care fraud, please call our toll-free number 1 (866) 888-3322.

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GENERAL INFORMATION

INTRODUCTION

As a covered employee under the U. S. Department of Labor's Energy Employees Occupational Illness Compensation Program (EEOICP) you are entitled to medical benefits to cover the reasonable cost of treatment and care of your accepted medical condition(s), as well as reimbursement related to preapproved travel and durable medical equipment, under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

This booklet covers the most frequently asked questions by EEOICP claimants. While this booklet provides basic information about your medical benefits, it is not intended to cover every possible exception or special case, and it does not have the effect of law or regulations.

For further information about special circumstances or individual cases, please contact one of our Resource Centers or your claims examiner at the EEOICP District Office. Resource Center and EEOICP District Office contact information is listed at the end of this booklet.

MEDICAL BILL PROCESSING AGENT

Throughout this booklet, Conduent is referred to as the 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
  Monday-Friday 8:00 a.m. to 8:00 p.m. (ET)

- Internet address:
  http://owcpmed.dol.gov

CLAIM FORMS

Claim forms may be obtained from the following sources:

- Resource Centers listed at the end of this booklet

- District Offices address is listed at the end of this booklet

- EEOICP website:
  https://www.dol.gov/owcp/energy/regs/ compliance/claim_forms.htm

- Medical bill processing agent website:
  http://owcpmed.dol.gov

You may also call one of the Resource Centers listed at the end of this booklet to obtain forms and information.

REIMBURSEMENT OF RETROACTIVE MEDICAL AND PRESCRIPTION EXPENSES

HOW WILL I RECEIVE REIMBURSEMENT FOR RETROACTIVE MEDICAL BILLS AND PRESCRIPTION EXPENSES FOR MY ACCEPTED CONDITION(S)?

You may request reimbursement for out-of-pocket expenses for medical treatment and prescriptions for your accepted condition(s) that were incurred prior to the acceptance of your claim. Reimbursement of expenses is allowed retroactive to the filing date of the claim.

To be considered for payment, bills must be submitted by the end of the calendar year after the year when the expense was incurred, or by the end of the calendar year after the year when the claim was first accepted as compensable by the Department of Labor.

Example: A claim is accepted on January 2, 2005. The filing date of the claim is January 1, 2003. Reasonable and customary medical treatment and prescription bills that were incurred between January 1, 2003 and January 1, 2005 for the accepted condition are reimbursable but must be submitted no later than December 31, 2006 on form OWCP-915.

You may obtain the required forms on-line at the EEOICP and medical bill processing agent websites:

https://www.dol.gov/owcp/energy/regs/compliance/claim_forms.htm

http://owcpmed.dol.gov

EEOICP MEDICAL BENEFITS IDENTIFICATION CARD

WILL I RECEIVE A MEDICAL BENEFITS IDENTIFICATION CARD?

YES, if you are the covered employee. Once you are awarded medical benefits under the EEOICP, you will receive an EEOICP Medical Benefits Identification Card. The card is white with a Department of Labor logo, and is imprinted with your name, 10-digit Card ID Number, Benefits Identification Number (BIN) and DEEOIC Group ID Number for pharmacy point-of-sale submissions. It includes a statement that no co-pay or deductible is required and the medical bill processing website: http://owcpmed.dol.gov where you or your provider can view the status of submitted bill(s), authorization request(s), covered medical services, and your accepted medical condition(s). The card is to be presented at the time of treatment for your accepted condition(s).

In order for you to access the website, you must have your 10-digit Card ID Number (located on the front of the card), Social Security Number (to be entered in the field labeled “Case File Number”) and date of birth.

The back of your card includes the address to submit bills, and the toll-free customer service number 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

See Sample of the EEOICP Medical Benefits Identification Card on page 13.

WHEN DO I USE MY EEOICP MEDICAL BENEFITS IDENTIFICATION CARD?

You should present your EEOICP Medical Benefits Identification Card whenever you seek treatment for your accepted condition(s). Showing the medical provider your EEOICP Medical Benefits Identification Card will help the medical provider determine the proper way to bill for services. You also must provide your Social Security number to the medical provider when you present your EEOICP Medical Benefits Identification Card.

IF MY EEOICP MEDICAL BENEFITS IDENTIFICATION CARD IS LOST OR DESTROYED, WHO SHOULD I CONTACT?

You should call the medical bill processing agent toll-free at (866) 272-2682.

COVERED MEDICAL CONDITIONS

The medical condition(s) accepted in your claim are covered for medical benefits from the day you filed a claim for those conditions. In addition to these accepted conditions, the EEOICP will cover any consequential illnesses as a result of your accepted condition(s).

WHAT IS A CONSEQUENTIAL ILLNESS?

A consequential illness is a new and separate medical problem that is identified by your doctor as having developed due to the original accepted illness.

MEDICAL BENEFITS

WHAT MEDICAL BENEFITS ARE PROVIDED UNDER THE EEOICP?

Medical benefits for covered illnesses include reasonable and customary medical care, drugs prescribed by a physician, and travel directly associated with the treatment of a covered illness. You do not pay a deductible or a co-payment. An established list of maximum dollar allowances for services is utilized in the payment of medical bills. The following is a list of some of the services that may be covered for the treatment of your accepted illness(s):

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

WHERE SHOULD MEDICAL PROVIDERS SEND BILLS RELATED TO THE EEOICP?

Bills for medical services covered under the EEOICP should be mailed to the medical bill processing agent at:

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

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

The following medical expenses may be covered under the EEOICP, but require review and approval by your claims examiner ***before*** you incur the expense:

- 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)
- If you need a companion for travel to a medical appointment, a letter from your physician stating the medical necessity for the companion must be submitted to your claims examiner.
- Special equipment as prescribed or recommended by your treating physician
- Durable medical equipment
- Any health or gym facility membership
- Home exercise equipment
- Home modifications
- Automobile modifications
    - ***NOTE:*** Requests for modifications for home or auto require two estimates from a certified or licensed builder or dealer
- Organ or stem cell transplants
- Medical documentation retrieval
- Home Health Services
- Rehabilitative Therapy
    - Physical Therapy
    - Occupational Therapy
    - Speech Therapy
- Nursing home or assisted living facility
- Hospice care
- Psychiatric treatment
- Chiropractic treatment
- Acupuncture treatment

WHAT COSTS ARE NOT COVERED UNDER THE EEOICP?

The following are some of the most common costs not covered under the EEOICP:

- Treatment of medical conditions not related to your accepted condition(s)
- Medical treatment for anyone other than yourself (example: spouse and children are not covered under the EEOICP)
- Medicines that are not prescribed by a doctor
- Prescriptions for non-accepted conditions under the EEOICP
- Personal services in the hospital (example: telephone or television)
- Sales Tax

If you have any questions, you may call the medical bill processing agent toll-free at (866) 272-2682.

PAYMENT FOR MEDICAL TREATMENT

HOW WILL MY COVERED MEDICAL BILLS GET PAID?

We strongly encourage you to present your EEOICP Medical Benefits Identification Card to the medical provider whenever you seek treatment for your accepted condition(s). If your medical provider is enrolled in the program, the EEOICP will pay them directly. If your medical provider is not enrolled in the program, they can call toll-free at (866) 272-2682 for enrollment assistance. You may also pay for medical services and then request reimbursement of these expenses.

WHAT IF THE MEDICAL PROVIDER WANTS TO BILL MEDICARE OR ANOTHER INSURANCE CARRIER INSTEAD OF THE EEOICP?

The EEOICP provides primary medical coverage for the accepted conditions, and those medical bills should always be sent to the EEOICP medical bill processing agent. Insurance carriers, Medicare or Medicaid should not be billed for treatment of the accepted conditions.

DOES THE MEDICAL PROVIDER SUBMIT BILLS ON A BILLING FORM?

YES. Medical providers must itemize their charges on the standard health insurance claim forms used throughout the medical community.

- A doctor, clinic, laboratory, ambulance or nursing service will bill the EEOICP using Form OWCP-1500
- A hospital will bill the EEOICP using the Form OWCP-04 for all charges incurred for inpatient, outpatient, emergency room, surgical, and chemotherapy services.

Forms may be obtained from the Resource Centers or the EEOICP and medical bill processing agent's websites:

- https://www.dol.gov/owcp/energy/regs/compliance/claim_forms.htm
- http://owcpmed.dol.gov

MEDICAL PROVIDERS ENROLLED IN THE PROGRAM

HOW CAN I DETERMINE IF A MEDICAL PROVIDER IS ENROLLED IN THE EEOICP?

A provider search feature is on the medical bill processing agent's website:

- http://owcpmed.dol.gov

You should also check with your medical provider for information on whether they are enrolled in the EEOICP. If your physician is not enrolled, he or she may contact the medical bill processing agent or a Resource Center for enrollment information.

HOW CAN A MEDICAL PROVIDER OBTAIN ENROLLMENT AND BILLING INFORMATION?

A medical provider may obtain enrollment and billing information by calling the medical bill processing agent toll-free at (866) 272-2682 or one of the Resource Centers listed at the end of this booklet. Enrollment forms are available on the medical bill processing agent's website:

- http://owcpmed.dol.gov

PRESCRIPTION BENEFITS

WHAT DRUGS ARE COVERED UNDER THE EEOICP?

Most drugs prescribed by your doctor for treatment of your accepted condition(s) will be covered (brand name or generic), but some may not. To check if a drug is covered, you or your pharmacist may call the medical bill processing agent toll-free at (866) 272-2682. You will need the 11 digit national drug code for each medication to verify coverage.

HOW DOES THE PHARMACY BILL THE EEOICP FOR MY COVERED PRESCRIPTIONS?

Present your EEOICP Medical Benefits Identification Card to a pharmacy that is enrolled in the EEOICP. The pharmacy will bill the EEOICP for your covered prescription electronically via Point of Sale (POS). If the prescription is covered, you will not be charged any deductible or co-payment.

WHAT IF THE PHARMACY IS NOT ENROLLED WITH THE EEOICP?

If the pharmacy is not enrolled as a provider, you may pay for your prescription, and then submit a request for reimbursement on the Form OWCP-915, *Claim for Medical Reimbursement (See Sample on page 15).*

If you pay for your covered prescription, you may submit a request for reimbursement to the medical bill processing agent. Reimbursement of out-of-pocket expenses may be subject to an established list of maximum dollar allowances for medical services.

REIMBURSEMENT OF MEDICAL EXPENSES

HOW DO I GET REIMBURSED 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 (See Sample on page 14).* In addition, you must submit the following items which are to be attached securely to the form:

- Provider's itemized billing statement to include a clear receipt of payment to your provider; and description of service.
- 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.

Up to eight visits or services can be listed on one form if the service was provided by the same medical provider. Each entry must be filled in completely. Receipts may be attached in lieu of listing each item. Mark the item "See Attached." A separate form must be completed for different medical providers.

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

WHAT IS THE TIME LIMIT FOR SUBMITTING A REQUEST FOR REIMBURSEMENT?

Requests for reimbursement must be submitted by the end of the calendar year after the year when the expenses were incurred, or by the end of the calendar year after the year when the claim was first accepted as compensable by the Department of Labor.

REIMBURSEMENT OF PRESCRIPTION EXPENSES

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

To obtain reimbursement, complete Form OWCP-915, *Claim for Medical Reimbursement (See Sample on page 14).* In addition, you must submit original pharmacy receipts which are to be attached securely to the form.
Note: If you send an itemized computer printout, it must include all the below information, and the pharmacist's original signature.

Acceptable receipts include any of the following:

- Pharmacy bag or sticker containing the payment information
- Computerized printout of itemized bill to include a clear description of services and/or drugs
- Itemized listing on pharmacy's letterhead

The receipts must include:

- Your full name and address
- Date prescription filled
- Name of prescribing doctor
- Name and address of pharmacy
- Name of each drug
- Prescription number
- 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 (example: 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.***

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

A copy of the front and back of your cancelled check or statement from your credit or debit card may serve as proof of payment only when accompanied by an itemized bill or pharmacy ledger record.

If you need help in obtaining or completing forms, you may contact one of the Resource Centers listed at the end of this booklet. You may also contact the medical bill processing agent toll-free at (866) 272-2682. Forms may also be obtained on the EEOICP and the medical bill processing websites:

- https://www.dol.gov/owcp/energy/regs/compliance/claim_forms.htm
- http://owcpmed.dol.gov

Up to eight prescriptions can be listed on one form if purchased from the same pharmacy. Each entry must be filled in completely. Receipts may be attached in lieu of listing each item. Mark the item "see attached." A separate form must be completed for each different pharmacy.

REIMBURSEMENT OF TRAVEL EXPENSES FOR MEDICAL TREATMENT

CAN I BE REIMBURSED FOR THE COST OF TRAVEL FOR MEDICAL TREATMENT OR TO PICK UP PRESCRIPTIONS RELATED TO MY ACCEPTED CONDITION(s)?

YES. You may be reimbursed for the cost of travel for medical treatment or to pick up prescriptions related to your accepted condition(s).

You may be reimbursed for mileage for travel to obtain medical treatment or prescriptions for your accepted condition(s). Authorization is not required for travel by privately owned vehicle (POV) that does not exceed 200 miles roundtrip. Reimbursement for mileage is based on the rate established by the General Services Administration, which can be found on their website at www.gsa.gov. You may also contact one of the Resource Centers for assistance.

Overnight travel, any travel other than by POV, and POV travel that exceeds 200 miles roundtrip requires authorization from your claims examiner in the District Office prior to travel. Upon authorization, which may cover multiple trips, you will receive an approval letter and further information. District Offices are listed at the end of this booklet.

Authorized overnight travel, lodging and meals and incidental expenses (M&IE) will be reimbursed according to the federal government per diem rate, and is based on the travel location. If a travel companion is required, you must obtain authorization from your claims examiner at the District Office ***prior to travel***. An additional daily allowance will be paid for the travel companion. The per diem rates can be found on the General Services Administration website at www.gsa.gov.

The reimbursement for lodging will be the actual amount, but not to exceed the daily federal government per diem rate. Lodging receipts must be submitted with the travel reimbursement request.

The reimbursement for M&IE is based on a daily, flat-rate allowance for each day of authorized travel, and receipts are not required. The first and last days of travel are reimbursed at 75% of the M&IE allowance. 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. Receipts must be submitted for reimbursement of any allowable expense of $75 or more.

Receipts are always required, regardless of amount, for lodging, airfare, rental cars and gasoline purchases for rental cars. The Resource Center can answer questions and assist you with expense processing.

To obtain reimbursement for covered travel expenses, complete the Form OWCP-957, *Medical Travel Refund Request (See sample on page 17)*. Up to three single days of travel can be listed on each form.

The Form OWCP-957, block 5d "Travel To" does not include a check box for "pharmacy." Therefore, check the boxes "home" to "home." Box 5e, "Medical facility name and address" must include the pharmacy name, city, state and zip code for each visit. Your signature and the date the form was signed are required in box 8.

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?

A reimbursement request that is submitted correctly will be processed 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 correction or additional information, the medical bill processing agent will attempt to 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 very important that you make the required corrections and return these materials as soon as possible. You cannot be reimbursed until the required documentation is submitted properly.

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, you may call one of the Resource Centers listed at the end of this booklet. You may also call the medical processing agent toll-free at (866) 272-2682.

REMITTANCE VOUCHERS

WILL I BE NOTIFIED IF MY REIMBURSEMENT REQUEST WILL BE PAID OR DENIED?

YES. You will receive a remittance voucher *(See sample on page 18)* by mail that will notify you if your reimbursement has been paid or denied. You will not receive a remittance voucher if your medical provider directly billed the Department of Labor.

A remittance voucher is a form mailed to you by the medical bill processing agent after a request for reimbursement is processed. It 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
- If a payment is denied, an explanation of benefits will be located at the bottom of the remittance voucher, and will explain why any portion of the reimbursement request was denied.

Retain the remittance voucher to compare it against the check you will receive.

WILL A CHECK BE INCLUDED WITH THE REMITTANCE VOUCHER?

NO. The check is always mailed separately. Checks are issued by the U. S. Department of Treasury. You should receive the check within 14 days after you receive the remittance voucher. The check and the remittance voucher will contain the same remittance voucher number, reference number, date paid, and amount paid. If you need assistance or do not receive the check within 14 days, please call the medical bill processing agent or one of the Resource Centers listed at the end of this booklet.

Electronic Funds Transfer (EFT) is offered as another payment method. The EFT payment method will speed payment delivery by depositing payments directly to

your bank, credit union, or other financial institution's account. The EFT payment method is optional and is ***not*** a requirement by the Department of Labor; just a quicker and convenient method in which you can receive your payment.

MEDICAL BENEFITS FOR CLAIMS FILED BY SURVIVORS

WHEN 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 will be awarded for the accepted condition(s) for medical expenses incurred from the date the employee filed the claim to the date of death of the employee.

HOW DO I REQUEST REIMBURSEMENT FOR COVERED MEDICAL BILLS?

A request for reimbursement of out-of-pocket expenses incurred by the employee for medical treatment and prescriptions for the accepted illness(s) should be submitted by the surviving claimant on Form OWCP-915, *Claim for Medical Reimbursement (See Sample on page 14)*, along with the appropriate documentation. The payment will be issued to the estate of the deceased employee.

ARE OUTSTANDING MEDICAL EXPENSES PAID TO A MEDICAL PROVIDER?

If a medical expense for treatment of an accepted illness(s) was incurred during the covered time period, and it remains outstanding, with a medical provider who is enrolled in the EEOICP, 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.

You may obtain the required forms on-line at the EEOICP and medical bill processing agent's websites:

- https://www.dol.gov/owcp/energy/regs/compliance/claim_forms.htm
- http://owcpmed.dol.gov

You may also call one of the Resources Centers listed at the end of this booklet to obtain forms and information.

WHO TO CONTACT FOR ASSISTANCE WITH YOUR CLAIM

IF I CHANGE MY MAILING ADDRESS, WHO DO 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, Kentucky 40742-8306, or
upload the information directly using the Energy Document Portal at:
https://eclaimant.dol-esa.gov.

SHOULD I KEEP COPIES OF THE BILLS I SUBMIT?

YES, if possible. Keeping copies will give you a record of your reimbursement requests and the receipts submitted. The cost of copying forms and receipts is not reimbursed.

DEEOIC DISTRICT OFFICES & AREAS COVERED

The DEEOIC maintains four district offices nationwide that process claims under the EEOICPA. District Offices are located in Cleveland, Ohio; Denver, Colorado; Jacksonville, Florida; and Seattle, Washington, with jurisdiction based on the location of the employee's last employment. The mailing address for the district offices is:

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

DEEOIC RESOURCE CENTERS & REGIONAL JURISDICTION

The EEOICP has established 11 Resource Centers nationwide to assist employees and their families apply for benefits under the EEOICP. If you need help with any part of your EEOICP claim, including the medical billing process, you may contact one of the Resource Centers. They can provide assistance either in person or over the telephone; and therefore, are able to service individuals who are outside the immediate geographical area. The Resource Center you should contact for assistance is based on the location of the employee's last employment. The Resource Centers, including their regional jurisdiction, are listed below:

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

California-Hawaii

Denver Resource Center
8758 Wolff Court, Suite 101
Westminster, Colorado 80031
Main: (720) 540-4977
Fax: (720) 540-4976
Toll Free: (866) 540-4977

Colorado-Wyoming-Kansas
Nebraska-Oklahoma-Iowa

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

New Mexico-Texas

Hanford Resource Center
303 Bradley Blvd., Suite 104
Richland, Washington 99352
Main: (509) 946-3333
Fax: (509) 946-2009
Toll Free: (888) 654-0014

Washington-Oregon-Alaska

Idaho Resource Center
Exchange Plaza
1820 East 17th Street, Suite 250
Idaho Falls, Idaho 83404
Main: (208) 523-0158
Fax: (208) 557-0551
Toll Free: (800) 861-8608

Idaho-North Dakota-Utah-South Dakota-Montana

Las Vegas Resource Center
Flamingo Grand Plaza
1050 East Flamingo Rd., Suite W-156
Las Vegas, Nevada 89119
Main: (702) 697-0841
Fax: (702) 697-0843
Toll Free: (866) 697-0841

Nevada-Arizona

New York Resource Center
6000 North Bailey Avenue
Suite 2A, Box #2
Amherst, New York 14226
Main: (716) 832-6200
Fax: (716) 832-6638
Toll Free: (800) 941-3943

Maine-New Hampshire-Vermont-Massachusetts
New York-Connecticut-New Jersey-Rhode Island
Delaware-Pennsylvania-Maryland

Oak Ridge Resource Center
Jackson Plaza Office Complex
800 Oak Ridge Turnpike
Suite C-103
Oak Ridge, Tennessee 37830
Main: (865) 481-0411
Fax: (865) 481-8832
Toll Free: (866) 481-0411

Tennessee-Mississippi-Alabama-Louisiana
Arkansas-Virginia

Paducah Resource Center
Barkley Center, Unit 125
125 Memorial Drive
Paducah, Kentucky 42001
Main: (270) 534-0599
Fax: (270) 534-8723
Toll Free: (866) 534-0599

Kentucky-Indiana-Illinois-Missouri

Portsmouth Resource Center
1200 Gay Street
Portsmouth, Ohio 45662
Main: (740) 353-6993
Fax: (740) 353-4707
Toll Free: (866) 363-6993

Ohio-Michigan-Wisconsin-Minnesota
West Virginia-Puerto Rico

Savannah River Resource Center
1708 Bunting Drive
North Augusta, S.C. 29841
Main: (803) 279-2728
Fax: (803) 279-0146
Toll Free: (866) 666-4606

South Carolina-North Carolina-Georgia-Florida

Sample EEOICP 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 A Smith

Card ID Number: 1234567899

Pharmacy BIN: 610084

DEEOIC Group ID #: OWCP1222

No Co-Pay/No Deductible
Verify Eligibility and Coverage at:
http://owcpmed.dol.gov

MISUSE OF CARD 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.
4. All bills should be submitted to the Energy Employees Occupational Illness Compensation Program, P.O. Box 8304, London, KY 40742-8304.
5. If found, drop in mailbox. Postage guaranteed. Return to: Energy Employees Occupational Illness Compensation Program, P.O. Box 8304, London, KY 40742-8304.
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 Card ID number located on the front of the card. Claimants can use this card ID number to access the DOL OWCP website.

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

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)

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	[x]	[ ]
OFFICE VISIT	12/22/2014	12/22/2014	$65.00	[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 A. 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

Smith	John	A
Last	First	M.I.

OWCP File Number: 123-45-6789

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

Telephone Number: (000) 123-4567

Tunnelsport	PA	16600
City	State	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)

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

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. 108. 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: 12/31/2016

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 on the back of form)

4. Claimant's/Payee's Address (Street/RFD, City, State, Zip Code): 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 ☒ Round Trip c. Travel From: ☐ Hospital ☐ Office/clinic ☐ Lab ☒ Home d. Travel To: ☐ Hospital ☒ Office/clinic ☐ Lab ☐ Home e. Medical Facility Name and Address: Tunnelsport Clinic, 156 Crain Lane, Tunnelsport, PA 16660	f. Total expense/cost ☐ Taxi $ ☐ Bus/Train ☒ Tolls/Pkg 2.50 ☐ Lodging ☐ Meals ☐ Other (Specify) g. Private Auto Only Miles traveled 15	**DOL USE ONLY** **TOS/Procedure 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: 06/23/2015 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: Tunnelsport Clinic, 156 Crain Lane, Tunnelsport, PA 16660	f. Total expense/cost ☐ Taxi $ ☐ Bus/Train ☒ Tolls/Pkg 2.50 ☐ Lodging ☐ Meals ☐ Other (Specify) g. Private Auto Only Miles traveled 15	**DOL USE ONLY** **TOS/Procedure 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/Procedure 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 hereby certify that the information given by me on and in connection with this form is true and correct to the best of my knowledge and belief. 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.

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

Form OWCP-957
Rev. Aug 2003

Sample Remittance Voucher

```
1
 DOLC8000-R0011                               2                                   3
 AS OF 04/01/04                1        R E M I T T A N C E   V O U C H E R                                                 RUN DATE 03/27/04
 0
 0TO: JOHN A SMITH                  RV NO.:  1234767   REFERENCE NO.: 1234567    DATE PAID 04/01/04    CLAIMANT NUMBER: 123456789        PAGE:        1

 0PROVIDER NAME        TRANS-CONTROL-NUMBER      /BC-IND /    BILLED        FEE REDUCTION      ALLOWED      LESS        PAID        MED REC    NUM /
                  LI         DATE       CODES      UNITS        AMOUNT            AMOUNT          OTHER      AMOUNT      AMOUNT      PERFORM    PROV        EOB      EOB

 0                         * * *  BILL TYPE:    HCFA 1500                 * * *  BILL STATUS:  PAID
                                                     4                                              6                    7
 ORIGINAL BILLS:

 0CLAIMANT TRAVEL PAY-TO PROVIDER
                   0-04072-71-001-0001-00                    43.30        0.00          43.30      0.00        43.30
        5          01     10/01/03    E1399        1          43.30        0.00          43.30 B    0.00        43.30            999999991


                           * * *  BILL TYPE:    HCFA 1500                  * * *  BILL STATUS:  DENIED
                                                                                                                         9
 ORIGINAL BILLS:

 0CLAIMANT TRAVEL PAY-TO PROVIDER
                   0-04072-71-001-0002-00                   163.78        0.00          0.00       0.00        0.00
        8          01     11/05/03                 1          34.99        0.00          0.00       0.00        0.00            999999991       172
                   02     11/24/03                 1          23.14        0.00          0.00       0.00        0.00            999999991       172
                   03     12/09/03                 1         105.65        0.00          0.00       0.00        0.00            999999991       103
       PREVIOUS-DATE-PAID: 03/11/04 CONFLICTING-TCN: 0-0454-41-001-0001-00
 R E M I T T A N C E   T O T A L S
 PAID ORIGINAL BILLS:          NUMBER OF BILLS          1            43.40                                     43.30
 PAID ADJUSTMENT BILLS:        NUMBER OF BILLS          0             0.00                                      0.00
 PAID CAPITATION:              NUMBER OF BILLS          0             0.00                                      0.00
 DENIED ORIGINAL BILLS:        NUMBER OF BILLS          1           163.78                                      0.00
 DENIED ADJUSTMENT BILLS:      NUMBER OF BILLS          0             0.00                                      0.00
 DENIED CAPITATION:            NUMBER OF BILLS          0             0.00                                      0.00
 PENDED BILLS (IN PROCESS):    NUMBER OF BILLS          0             0.00                                      0.00
 AMOUNT OF CHECK       ---------------------------------------------------------------------------              43.30

 0----   THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:                           COUNT
 10
    103   BILLED SERVICE DENIED.  DUPLICATE OF A SERVICE PREVIOUSLY PAID                                                  1
     72   NO VALID AMA CPT-4 OR OTHER APPROVED CDE LISTED
```

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How to Read Your Remittance Voucher (RV):

1. *RV NO: Each RV created has its own unique number and it will appear on any checks sent by DOL.*
2. *Reference Number: When you receive your check, this reference number will be printed on it. This will help you match the check to the RV.*
3. *The RV will show the date the bills were paid and the claimant number on the bills.*
4. *Bills are grouped by Bill Type.*
5. *TCN – Transaction Control Number. Xerox assigns an internal tracking number for each bill processed. When calling with inquiries about a specific bill, please have this number ready.*
6. *Bills are also grouped by payment status.*
7. *Treating Provider. For claimant-submitted bills, the default value is 999999991.*
8. *Detail is provided for each line of a bill.*
9. *EOB codes post when a line or entire bill denies.*