Print Reset

Office of Workers' Compensation Programs (OWCP)

Bill Adjustment Request Form

Program Name: Select *

TCN: * (Min 17- Max 18 digits)

OWCP Provider ID: * (9 digits)

Claimant Case ID: (Min 3 and Max 16 characters)

Claimant Name: (First Name and Last Name)

Reason for Adjustment (check all that apply)**:**

- ☐ Keying Errors
- ☐ Incorrect Charges
- ☐ Incorrect denial (authorization,proof of timely filing,and etc)
- ☐ Return Funds

Explanation for Adjustment:

INSTRUCTIONS:

Please submit replacement bill for original TCN which includes all lines. Please mail the documents with all attachments.

THIS COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR MAIL WITH ALL SUPPORTING DOCUMENTATION BEHIND THIS COVER SHEET.

Signature: **Date:**

DFEC	DEEOIC	DCMWC	DLHWC
U.S. Department of Labor, DFEC Central Mailroom - Bills and Authorizations, PO Box 8300, London, KY 40742-8300.	U.S. Department of Labor, DEEOIC Central Mailroom - Bills and Authorizations, PO Box 8304, London, KY 40742-8304.	U.S. Department of Labor, DCMWC Central Mailroom - Bills and Authorizations, PO Box 8302, London, KY 40742-8302.	U.S. Department of Labor, DLHWC Central Mailroom - Bills and Authorizations, PO Box 8313, London, KY 40742-8313.