



**Office of Workers' Compensation Programs (OWCP)**  
**Bills Supporting Documents Cover Sheet**

**Program Name:**  \*

**Claimant Case Id:**  \* (Min 3 - Max 16 characters)

**Claimant Name:**  (First Name and Last Name)

**Identifier Type:**  \*

**Identifier Value:**  \*

**OWCP Provider ID:**  \* (9 digits)

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

DFEC	DDEOIC	DCMWC	DLHWC
U.S. Department of Labor OWCP/ DFEC PO Box 8300 London, KY 40742-8300	U.S. Department of Labor OWCP/ DDEOIC PO Box 8304 London, KY 40742-8304	U.S. Department of Labor OWCP/ DCMWC PO Box 8302 London, KY 40742-8302	U.S. Department of Labor OWCP/DLHWC PO Box 8313 London, KY 40742-8313