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CARRIER REIMBURSEMENT TEMPLATE

1. PATIENT'S NAME (*Last name, First name, middle initial)*	2. OWCP FILE NUMBER/ CASE ID 2.a Date of illness or Injury:
3. PATIENT ADDRESS Address1: Address2: City: State: Zip Code:	4. CARRIERS NAME: Address1: Address2: City: State: Zip Code: Carrier OWCP Provider ID: EIN: Phone:

5. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate diagnosis to procedure in column 6D by reference numbers A,B,C etc.) 5.a ICD IND:

A.	E.	I.
B.	F.	J.
C.	G.	K.
D.	H.	L.

6. A DATE OF SERVICE		B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN.		D DIAGNOSIS INDICATOR	E UNITS	F CHARGES	G CARRIER'S PAYMENT
FROM	TO		PROCEDURE Codes (CPT/HCPC)/ RCC Codes	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)				
					Total Charge:		Amount Paid:	

7. PHYSICIAN'S OR SUPPLIER'S NAME: Address1: Address2: City: State, ZIP: NPI:	8. SIGNATURE OF CARRIER'S REPRESENATIVE (I certify that the above documentation is reflected in the carriers official files) Signature Date:	9. PHOTOCOPIES YES NO BILLS: ☐ ☐ CANCELLED CHECKS/ REMITTANCE VOUCHERS : ☐ ☐	10. BILL TYPE: ○ 1500 ○ UB04 UB04 TYPE OF BILL: UB04 ADMISSION TYPE: UB04 PATIENT STATUS CODE STATEMENT COVERS PERIOD:

INSTRUCTIONS

This template should only be used by Providers Enrolled with the FECA, DEEOIC and DCMWC Programs under Provider Type 95 (Third Party Carriers) Note: The omission of the OWCP File Number (item 2) will delay bill processing. For Item 6C, the following information must be entered: The CPT/ HCPCS Procedure Code for professional services originally billed on the HCFA-1500 including NDC and unit of measure for unlisted J-codes, or the RCC and Procedure Code combinations for Outpatient services originally billed on the UB04 including NDC and unit of measure for unlisted J-codes, or Revenue Center Codes (RCC) for Inpatient Services. The Diagnosis Indicator in (item 6D) must be entered for each separate diagnosis listed in item 5, using the International Classification of Diseases; (ICD-10 CM) coding structures. The original HCFA-1500 for professional services, and/or the original UB04 for Inpatient and/or Outpatient services, and/or the copy of canceled check or remittance voucher and any other supporting documentation required by OWCP or program policy must be attached to the submitted Carrier Reimbursement Template, or the submitted bill will be returned to the carrier.

FORM SUBMISSION:

Send all bill forms for FECA (DFEC) to the DFEC Central Mail room, PO Box 8300, London KY 40742-8300.
Send all bill forms for Energy (DEEOIC) to the DEEOIC Central Mail room, PO Box 8304, London KY 40742-8304.
Send all bill forms for Black Lung (DCMWC) to the DCMWC Central Mail Room, PO Box 8302, London KY 40742-8302

INSTRUCTIONS FOR COMPLETING THE FORM: A brief description of each data element and its applicability to requirements under FECA, DEEOIC and DCMWC are listed below. For further information contact OWCP Toll Free: 1-844-493-1966.

Item-1: Enter the Patient's name
Item-2: For FECA enter the Patient's case file number. For DEEOIC and DCMWC enter the Case ID or SSN
Item-2A: For FECA enter the date of Illness/Injury. Not required for DEEOIC and DCMWC
Item-3: Enter the Patient's address(street address,city, state, Zip Code).
Item-4: Enter Carrier's name address, city, state, zip code.
Enter Carrier's OWCP Provider ID, EIN, Phone.
Item-5: Enter the diagnosis codes. **Note**: For UB04 enter the primary diagnosis codes in FIELD 5A.
Item-5A: Enter the ICD diagnosis version. Values are 0 for ICD-10, 9 for ICD-9.
Item-6A: Enter the date of service from and to date(MM/DD/YYYY)
Item-6B: Enter the CMS/OWCP standard "place of service" (POS) codes.
Item-6C: If bill type is a HCFA1500 enter the appropriate five-digit Procedure code, modifier(s). If the procedure code is an unlisted J-code, enter the NDC and unit of measure (mg, ml, gram, etc).
If the bill type for an Outpatient, enter the revenue codes (RCC) and Procedure code. If the procedure code is unlisted J-code, enter the NDC and unit of measure (mg, ml, gram, etc).
If the bill type is an Inpatient, enter the the revenue codes (RCC)
Item-6D: If bill type is an HCFA 1500, enter the diagnosis reference indicator (A,B,C,D from item 5) to relate the date of service and procedure(s) performed with appropriate ICD code.
Item-6E: Enter the number of units/services provided.
Item-6F: Enter the billed charges.
Item-7: Enter the servicing provider name, address, city, state, zip code, servicing provider NPI.
Item-8: Sign and date the form.
Item-9: Check the appropriate box for photocopies for bills
Check the appropriate box for "Cancelled checks/remittance vouchers"
Item-10: Check the appropriate bill type (1500 or UB04)
"UB04 Type of Bill": if the bill type is UB04, enter the type of bill classification using the appropriate 3 digit code. 1st position indicates type facility, 2nd type of position indicates type of care, 3rd position indicates billing sequence.
"UB04 Admission Type": If the bill type is UB04, enter the admission type code.
"UB04 Patient Status Code": If the bill type is UB04, enter the patient status code.
"Statement Covers Period"; If the bill type is UB04, enter the statements from and to date (MM/DD/YY).