

# Claimant Reimbursement Forms



# Overview

- Obtaining a Claimant Reimbursement Form
- Completing OWCP 915 for Medical Reimbursements
- Completing OWCP 915 for Pharmacy Reimbursements
- Completing OWCP 957A and 975B for Travel Reimbursements
- Reimbursement Form Submission



# Obtaining a Claimant Reimbursement Form

1 Go to <http://owcpmed.dol.gov>

2 Click Resources

3 Click Forms & References

The screenshot shows the homepage of the Office of Workers' Compensation Programs Medical Bill Processing Portal. The header is blue with the Department of Labor seal on the left, the text "Office of Workers' Compensation Programs" and "Medical Bill Processing Portal" in the center, and a search bar on the right. A navigation menu below the header includes "Home", "Provider", "Login", "Resources", "Pharmacy/LMN", "News", and "Contact Us". The "Resources" menu is open, showing a dropdown with "FAQs", "Forms & References", "Claimant Training & Tutorials", and "Fee Schedules". Below the navigation, there are three main content areas: "Provider" (with a "Get Started" button), "Need medical treatment?" (with "How to Search" and "Find a Provider" buttons), and a light blue banner with an information icon and the text "ATTENTION: Moving Toward a Fully-Electronic Medical Bill Processing System". At the bottom, there is a "COVID-19 Update" link.

# Obtaining a Claimant Reimbursement Form

- 4 Under Claimant Reimbursement, select **Claimant Medical/Pharmacy Reimbursement (OWCP 915)** or **Medical Travel Refund Request – Mileage (OWCP-957A)** or **Expenses (OWCP 957B)**.

## Forms and References

General

DCMWC

DEEOIC

DFEC

### 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 - Mileage \(OWCP-957A\)](#)

[Medical Travel Refund Request - Expenses \(OWCP-957B\)](#)

#### Provider Enrollment

[Provider Enrollment Application \(OWCP-1168\)](#)

[EDI Enrollment Template \(For Billing Agent/Clearinghouse Only\)](#)

[ACH Form](#)

[Supporting Document Cover Sheet](#)

# OWCP 915 Medical Reimbursement



## Instructions for use of FORM OWCP-915 Medical Reimbursement

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- 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

# 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. <b>DO NOT FILL IN SHADED AREAS.</b> 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
<b>PERSONAL INFORMATION</b>		
Name <input type="text"/> <input type="text"/> <input type="text"/> Last First M.I.		OWCP File Number <input type="text"/>
Address <input type="text"/> Street/P.O. Box/Apt No. <input type="text"/> <input type="text"/> City State Zip Code		Telephone Number <input type="text"/>
		FOR DOL USE ONLY

## Completing the OWCP 915 Medical Reimbursement form

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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)	



# 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
				<input checked="" type="checkbox"/>	<input type="checkbox"/>
				<input checked="" type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
			<b>Total Reimbursement</b>		

# 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.

# 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 **HCFA 1500 form**. This  
form can be submitted along with  
your 915 to ensure your bill is  
coded correctly and you are  
reimbursed for the proper services.

## Claim for Medical Reimbursement

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



Reset

Print

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 John A Last First M.I.	OWCP File Number 123-45-6789
Address 1234 Main St Street/P.O. Box/Apt No. Tunnelsport PA 16600 City State Zip Code	Telephone Number (000) 123-4567  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)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
Office Visit	02/01/2020	02/01/2020	\$65.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Office Visit	02/01/2020	02/01/2020	\$65.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

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 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. <b>DO NOT FILL IN SHADED AREAS.</b> 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
<b>PERSONAL INFORMATION</b>		
Name <input type="text"/>		OWCP File Number <input type="text"/>
Last	First	M.I.
Address <input type="text"/>		Telephone Number <input type="text"/>
Street/P.O. Box/Apt No. <input type="text"/>		FOR DOL USE ONLY
City <input type="text"/>	State <input type="text"/>	

# Completing the OWCP 915 Medical Reimbursement- Prescriptions Form

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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)	

# 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
				<input checked="" type="checkbox"/>	<input type="checkbox"/>
				<input checked="" type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
			<b>Total Reimbursement</b>		

# Completing the OWCP 915 Medical Reimbursement form

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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.



# 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 John A  
Last First M.I.

Address  
1234 Main St  
Street/P.O. Box/Apt No.  
Tunnelsport PA 16600  
City State Zip Code

OWCP File Number  
123-45-6789

Telephone Number  
(000) 123-4567

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)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
Tetracycline NDC 00182-0112-01	02/01/2020	02/01/2020	\$45.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Theodur NDC 00085-0487-01	02/01/2020	02/01/2020	\$85.00	<input checked="" type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

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 957A Travel Reimbursement-Mileage

This form is applicable to DFEC  
and DEEOIC programs.



# Completing the OWCP 957A Travel Reimbursement Form – Mileage

## 1 Enter your personal information

NOTE: This report is authorized by the Federal Employees' Compensation Act (5 USC 8103(a)) 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 mileage. 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 and the Energy Employees Occupational Illness Compensation Program Act of 2000. For travel expenses reimbursement under the Black Lung Benefits Act (30 USC 901; 20 CFR 725.406 and 725.701) use the Form OWCP-957 Part B

OMB No. 1240-0037  
Expires: 11/30/2026

1. Claimant Name (Last, First, M.I.):

2. Case/Claim Number:

3. Payee Name if different from claimant's name (Last, First, M.I.):  
(See Instruction No. 3 for further requirements if payee is not the claimant)

4. Claimant/Payee Phone No.:

5. Claimant/Payee Address (House #, Street or RR, City, State, Zip Code):

6. Claimant/Payee Email:

## Completing the OWCP 957A Travel Reimbursement form – Mileage

2 Enter the following information:

- a. In field **7a**, Enter the date or dates you traveled.
- b. In field **7b**, select your reason for travel.
- c. In field **7c**, select where you traveled from and to
- d. In field **7d**, enter the full name and address of the medical facility.
- e. In field **7e**, select if the trip was One-way or Round trip. Only select one box.
  - **One-way**: Leaving to go to a destination without returning to the place you left.
  - **Round trip**: Departing from your original location “A,” traveling to your destination “B,” and returning back to “A” (where you began).
- f. In field **7f**, enter the total miles traveled for the trip.

7a. Date(s) of Travel	7b. Reason for Travel	7c. From (Full name and street address)	7d. To (Full name and street address)	7e. One-way /Round trip	7f. Total # Miles
	<input type="checkbox"/> Hospital <input type="checkbox"/> Medical Appt. <input type="checkbox"/> Therapy/Rehab <input type="checkbox"/> Pharmacy <input type="checkbox"/> Med. Supply <input type="checkbox"/> Other			<input type="checkbox"/> One-way <input type="checkbox"/> Round trip	

## Completing the OWCP 957A Travel Reimbursement form – Mileage

**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.

Payee 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.

8. Claimant/Payee Signature:

Date:

Form OWCP-957 Part A  
November 2023

# OWCP 957B Travel Reimbursement-Expenses

This form is applicable  
to all programs.



# Completing the OWCP 957B Travel Reimbursement Form - Expenses

- 1 Enter your personal information.

<p>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.</p>		OMB No. 1240-0037 Expires: 11/30/2026
1. Claimant Name (Last, First, M.I.):	2. Case/Claim Number:	
<input type="text"/>	<input type="text"/>	
3. Payee Name if different from claimant's name (Last, First, M.I.):	4. Claimant/Payee Phone No.:	
<input type="text"/>	<input type="text"/>	
5. Claimant/Payee Address (House #, Street or RR, City, State, Zip Code):	6. Claimant/Payee Email:	
<input type="text"/>	<input type="text"/>	
7. Payee relationship to Claimant:	8. Reason Payee other than Claimant is requesting reimbursement:	
<input type="text"/>	<input type="text"/>	

# Completing the OWCP 957B Travel Reimbursement Form - Expenses

9. Complete a separate block for each medical facility, pharmacy, therapist, etc. visited.
  - a. In the **Date** field, enter the date of travel.
  - b. In the **From** field, enter the full street address of the location where your trip began.
  - c. In the **To** field, enter the full street address of the location where your trip ended.
  - d. In the checkboxes to the right of **From** field, select the checkbox indicating whether the trip was **one-way** or **round trip**.

9. CLAIMANT'S TRAVEL EXPENSE REIMBURSEMENT REQUEST	
<b>Date:</b>	
<b>From:</b>	<input type="checkbox"/> One-way <input type="checkbox"/> Round trip
<b>To:</b>	<input type="checkbox"/> Hospital <input type="checkbox"/> Medical Appt. <input type="checkbox"/> Therapy/Rehab <input type="checkbox"/> Pharmacy <input type="checkbox"/> Med. Supply <input type="checkbox"/> Other
<b>Total miles traveled (Private auto only):</b>	
<b>Other travel expenses:</b> (Attach receipts for each listed expense)	<input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> Pkg/Tolls <input type="checkbox"/> Taxi <input type="checkbox"/> Lodging <input type="checkbox"/> Meals <input type="checkbox"/> Other
<b>Specify "Other" expenses:</b>	



## Completing the OWCP 957B Travel Reimbursement Form - Expenses

9. Complete a separate block for each medical facility, pharmacy, therapist, etc. visited.
  - a. If you drove or were driven in a private car, in the **Total miles traveled** field, enter the number of miles here for mileage reimbursement.
 

**Note:** Claimants are reimbursed per mile and not based on a gas receipt. Ensure your miles include only whole numbers and not decimals. (**Example:** If you traveled 9.2 miles, enter 9 miles.)
  - b. In the **Other travel expenses** field, select the applicable checkboxes and enter the dollar amount spent in each category. Attach receipts for each item. If you use the "Other" checkbox, name the item in the line below the checkbox.

**Note:** If you use the "Other" checkbox, list the actual cost and specify the type of expense in the **Specify "Other" expenses** field.

9. CLAIMANT'S TRAVEL EXPENSE REIMBURSEMENT REQUEST		
Date:		
From:		<input type="checkbox"/> One-way <input type="checkbox"/> Round trip
To:		<input type="checkbox"/> Hospital <input type="checkbox"/> Medical Appt. <input type="checkbox"/> Therapy/Rehab <input type="checkbox"/> Pharmacy <input type="checkbox"/> Med. Supply <input type="checkbox"/> Other
<b>Total miles traveled (Private auto only):</b>		
<b>Other travel expenses:</b> (Attach receipts for each listed expense)	<input type="checkbox"/> Train	
	<input type="checkbox"/> Bus	
	<input type="checkbox"/> Pkg/Tolls	
	<input type="checkbox"/> Taxi	
	<input type="checkbox"/> Lodging	
	<input type="checkbox"/> Meals	
	<input type="checkbox"/> Other	
<b>Specify "Other" expenses:</b>		

# Completing the OWCP 957B Travel Reimbursement Form - Expenses

## For **Black Lung Use Only**:

The Physician must complete this section. Only one checkbox can be selected to describe the reason for services rendered.

- Treatment for Black Lung
- Not Black Lung Related
- Determination Testing for Black Lung

The Physician must enter diagnosis details to represent what the treatment is for, then sign and date the form.

For Black Lung Use Only	
DOL USE ONLY	CARE RENDERED
<b>TOS/Procedure Code</b> ----- \$ ----- ----- ----- ----- ----- ----- ----- ----- ----- ----- <b>Total \$</b> -----	To be completed by Physician: (Mark one box only) <input type="checkbox"/> Treatment for Black Lung <input type="checkbox"/> Not Black Lung Related <input type="checkbox"/> Determination Testing for Black Lung  _____ Diagnosis  _____ Signature of Physician  _____ Date Care Rendered

Do not complete this column. It is for DOL use only!!!

# Completing the OWCP 957B Travel Reimbursement form - Expenses

**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.

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.

**10. Claimant's/Payee's Signature:**

Date:

Form OWCP-957 Part B  
November 2023

# Requirements for Reimbursement of the OWCP 957A and 957B Forms

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

Claimant's last name and OWCP Claim Number must be listed on submitted attachments. Be sure to keep a copy for your records.

## **Black Lung Claimants:**

- Travel expenses for the miner are reimbursable
- Lodging or travel exceeding 100 miles one-way or 200 miles roundtrip requires prior authorization from the District Office
- Travel to pick up medicine, equipment, or supplies is not reimbursable

## **Energy Claimants:**

- Lodging or travel exceeding 100 miles one-way or 200 miles roundtrip requires prior authorization from the District Office
- Reimbursement of companion travel requires prior authorization from the District Office

## **DFEC Claimants:**

- Meals, lodging, and travel exceeding 100 miles roundtrip require prior authorization from the District Office

# You are ready to submit your claim!

Claimant Reimbursements can be submitted via mail to:

1

**Division of Federal  
Employees'  
Compensation Act (FECA)**

PO Box 8300 London, KY  
40742-8300

2

**Division of Energy  
Employees Occupational  
Illness Compensation  
(DEEOIC)**

PO Box 8304  
London, KY 40742-8304

3

**Division of Coal Mine  
Workers' Compensation  
(DCMWC)**

PO Box 8302  
London, KY 40742-8302

**Note:** If your bill is not processed within 28 days, contact a Customer Service Specialist.

# Thank you!

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

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Email: [CNSIOWCPOutreach@cns-inc.com](mailto: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