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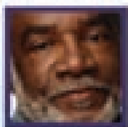
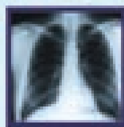
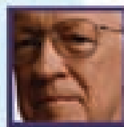
Black Lung Medical Benefits:

Questions and Answers about the Federal Black Lung Program



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

Black Lung Medical Benefits:

Frequently Asked Questions about the Federal Black Lung Program

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation
December 2004

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. Additionally, this information applies only if the Black Lung Disability Trust Fund 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(800)347-2502.

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Introduction

Like all coal miners who qualify for the U.S. Department of Labor's Federal Black Lung Program, you are entitled to medical benefits to cover the reasonable cost of treatment, services or supplies for your pneumoconiosis and disability (your black lung condition). Spouses, family members, and survivors of coal miners are not entitled to medical benefits. You have the right to seek treatment from the medical provider (physicians, pharmacies, hospitals, etc.) of your choice. Most providers who are enrolled in the Federal Black Lung Program will bill the Federal Black Lung Program directly for you. But if the provider is not enrolled in the Federal Black Lung Program (or chooses not to bill directly), it will be necessary for you to pay for the services yourself then file with the Federal Black Lung Program on your own for reimbursement of these out-of-pocket payments.

The questions presented here are those most often asked by Black Lung Program beneficiaries about:

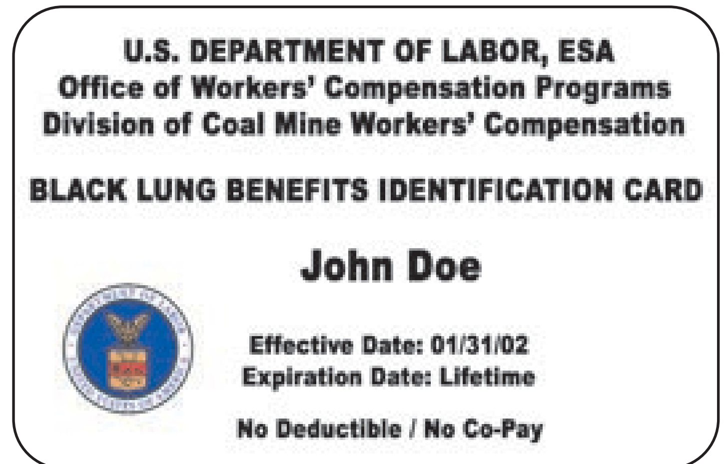
- The U.S. Department of Labor Black Lung Benefits Identification Card (medical treatment card);
- Medical benefits - covered and non-covered services; and,
- Reimbursement for medical care and associated travel.

While this material gives you basic information about your medical benefits, it is neither intended to cover every possible exception or special case, nor have the effect of law. Additionally, this information applies only if your medical benefits are being paid by the U.S. Department of Labor. 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 write or call the U.S. Department of Labor, Division of Coal Mine Workers' Compensation (DCMWC) District Office with which your claim is filed. For further information about special circumstances or individual cases, please write or call the District Office with which your claim is filed. If you are not sure which District Office handles your claim, you may find out by calling toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (ET): 1-800-638-7072.

1 What does the Black Lung Benefits Identification Card look like?

The U.S. Department of Labor Black Lung Benefits Identification Card is white with a Department of Labor logo, and is imprinted with your name, an effective date, and possibly an expiration date. The red-and-white cards previously issued are obsolete and should be destroyed. When medical providers bill the Federal Black Lung Program or when you submit reimbursement requests, your nine-digit Social Security number is your identification number. For privacy reasons, your Social Security number does not appear on your card. However, you will need to give your Social Security number to your medical treatment providers so they can bill correctly.

Sample 1. Black Lung Benefits Identification Card



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 this card with you at all times and show it to your doctor, clinic or hospital when you are in need of medical services for your lung condition.
3. The U.S. Department of Labor will pay for medical treatment that is authorized under the Black Lung Act. Call 1-800-638-7072 for specific details.
4. All bills should be submitted to the DOL Black Lung Program, P.O. Box 8302, London, KY 40742-8302.
5. If found, drop in mailbox. Postmaster, postage guaranteed. Return to: DOL Black Lung Program, P.O. Box 8302, London KY 40742-8302.
6. When using the DOL OWCP bill payment website (http://owcp.dol.acs-inc.com/) to request an authorization for medical services or to verify eligibility, your doctor must use the following Card ID Number: 1234567830. Claimants can also use this Card ID Number to access the DOL OWCP bill payment website.

MISUSE OF CARD IS PUNISHABLE BY LAW

2 Is my personal information safe? What does my doctor need to know?

Your Social Security number and address are not printed on the card, and this is information only you will know and will need to give to your medical providers. There is a 10-digit number printed on the back of the card that is unique to you. The purpose of this number is to allow the medical providers to access our secure web site to get information about your eligibility for benefits and about bills they have filed. Your providers will probably want to photocopy both sides of the card for their records, because without the card ID number they will be unable to access the secure part of our web site.

3 When do I use my U.S. Department of Labor Black Lung Benefits Identification Card?

You should present your black lung card whenever you seek treatment for your lung condition. Showing a medical provider your card will identify you as a Federal Black Lung Program beneficiary, and will help the medical provider determine the proper way to bill for services.

4 I receive my black lung benefits through the U.S. Department of Labor around the middle of each month, but I do not have a black lung card. What should I do?

Write or call the DCMWC District Office with which your claim is filed. If you are not sure which office handles your claim, call toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (ET), and the operator can tell you which District Office to contact: 1-800-638-7072.

5 I was awarded black lung benefits by the Federal Black Lung Program. I also filed a claim with the state where I worked as a coal miner and was awarded benefits for black lung. Am I still entitled to medical coverage under the Federal Black Lung Program?

Expenses for the treatment of your black lung condition that are not covered by the state program may be covered by the Federal Black Lung Program. However, bills or reimbursement requests must first be submitted under the state program which awarded your benefits.

If your medical providers' bills or your own reimbursement requests are denied under your state award, send the bill or the reimbursement request and original receipts (as discussed in Question 18), along with a copy of the denial letter, to:
FEDERAL BLACK LUNG PROGRAM
P.O. BOX 8302
LONDON, KY 40742-8302

If you have questions, please call the DCMWC District Office that handles your Federal Black Lung Program claim. If you do not have the address or phone number of that office, you may get them by calling toll-free, Mon.- Fri., 8:00 a.m.-8:00 p.m. (ET): 1-800-638-7072.

6 I have been awarded black lung benefits under both the Federal Black Lung Program and a State Workers' Compensation Program. Should I have received a black lung card?

If you have been awarded benefits for your black lung condition under a State Workers' Compensation Program, you will NOT receive an identification card from the Federal Black Lung Program. Expenses for the treatment of your black lung condition that are not covered by the state program may be covered by the Federal Black Lung Program. (See Question 5.)

7 What costs are covered under my Federal Black Lung Program medical benefits?

The cost of medical treatment services and associated travel for the treatment of your black lung condition is covered under the Federal Black Lung Benefits Act. Payment for medical treatment services is subject to a maximum allowable fee. There is no deductible or co-payment. Payment for travel is limited to reasonable costs.

The following is a list of services that MAY be covered when they are performed for the treatment of your black lung condition:

- Doctor's office calls, hospital visits, and consultations;
- Inpatient and outpatient hospital charges, including emergency room visits for ACUTE black lung related conditions, diagnostic laboratory testing and chest x-rays;
- Federal Black Lung Program APPROVED prescription drugs, both brand name and generic;
- Ambulance services limited to transportation to the hospital for emergency ACUTE black lung related care; and,
- Travel to the doctor, hospital, clinic, or other medical facility for round trips of 150 miles or less.

The following items require special approval:

- The purchase or rental of home medical equipment such as oxygen systems exceeding $300 (requires Certificate of Medical Necessity—See Question 10—completed by prescribing physician);
- Pulmonary rehabilitation (breathing retraining) programs (requires Certificate of Medical Necessity completed by prescribing physician);
- Home health care visits for skilled nursing (requires Certificate of Medical Necessity completed by prescribing physician); and,
- Overnight travel, related meals and lodging, and/or mileage that exceeds 150 miles round trip (requires special approval from your DCMWC District Office).

8 What prescription drugs are covered?

Most drugs prescribed by your doctor for the treatment of your black lung condition will be covered (brand name or generic). However, there are some exceptions. In order to be sure a drug is covered, you or your pharmacist may call toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (ET): 1-800-638-7072. Your pharmacist will also be able to learn at once if a drug is covered if the bill is submitted by Point-of-Sale technology.

9 Do I need prior approval for certain services?

Yes. Whether you or a medical provider does the billing, your doctor must complete the U.S. Department of Labor Certificate of Medical Necessity, CM-893 (CMN), for oxygen and other durable medical equipment, pulmonary rehabilitation, or skilled nursing care at home.

The doctor should send the completed form, with the results of the required medical tests attached, to the DCMWC District Office with which your claim is filed.

CMNs for rental items must be reapproved periodically (a prescription for oxygen concentrator, for example). All CMNs must have the DOCTOR'S ORIGINAL SIGNATURE. Your treating physician's original signature is the ONLY signature acceptable on the CMN. You, your physician, and the medical provider (if billing the Federal Black Lung Program for you) will be notified if the CMN has been approved or denied.

10 Where can my doctor get a Certificate of Medical Necessity (CMN)?

Your doctor may call the Federal Black Lung Program, toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (ET): 1-800-638-7072. The form is also available for downloading and printing from our website, at http://www.dol.gov/esa/regs/compliance/owcp/cm-893.pdf.

11 What costs are NOT covered by my Federal Black Lung Program medical benefits?

The following are among the costs NOT covered under the Federal Black Lung Program:

- Treatment of medical problems NOT related to your black lung condition —for example, arthritis, diabetes, and most heart conditions;
- Medical treatment for your spouse or other family members;
- Dental or eye care, and X-rays other than chest X-rays;
- Nurse's aid (non-skilled nursing care) services in the home;
- Home health aides
- Medicine that you can buy without a doctor's prescription;
- Medicine for problems other than your black lung condition;
- Personal services in the hospital, such as TV or telephone;
- Rental or purchase of an Intermittent Positive Pressure Breathing (IPPB) machine for home use;
- Travel to and from your drugstore;
- Residence costs (room and board) for nursing homes or skilled nursing facilities; and,
- Home medical equipment not authorized for coverage under the Federal Black Lung Program.

12 What is the best way to get my medical bills paid?

WHENEVER POSSIBLE, have your doctor, hospital, pharmacy and other medical providers bill the Federal Black Lung Program directly. If they are enrolled in the Federal Black Lung Program as providers, the Federal Black Lung Program will pay them directly. ALWAYS show your Black Lung Benefits Identification Card when seeking treatment.

13 How can a medical provider get enrollment and billing information from the Federal Black Lung Program?

Medical providers not already participating in the Federal Black Lung Program may apply for enrollment at any time. Those having questions about enrollment or billing may call the Federal Black Lung Program, toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (ET): 1-800-638-7072. They may also apply online at http://owcp.dol.acs-inc.com/portal/providerEnrollment.do.

14 Where should medical providers send Black Lung related bills?

Answer: ALL Federal Black Lung Program medical treatment bills should be sent to the following address:
FEDERAL BLACK LUNG PROGRAM
P.O. BOX 8302
LONDON, KY 40742-8302

15 Does the medical provider need special Department of Labor billing forms?

NO. The doctor, clinic, laboratory, ambulance and nursing service can bill using the standard OWCP-1500 form.

The pharmacy can bill using the standard OWCP-1500 form or the Universal Pharmacy Billing Form. They may also bill directly at the Point-of-Sale for most drugs.

The hospital can bill using the UB-92 form for all inpatient charges and outpatient charges for emergency room, chemotherapy and ambulatory surgical care. The OWCP-1500 form should be used for other outpatient charges.

16 What if the medical provider wants to bill Medicare, UMWA, or other insurance carriers instead of the Black Lung Program?

Other insurance carriers should NOT be billed first for treatment of your black lung condition, because Federal Black Lung Program medical benefits represent primary coverage for beneficiaries (unless there is a black lung award under a state program. See Question 5). Medicare and many other insurance carriers have a "workers' compensation exclusion clause." This means that they will not pay for treatment of occupational disease, like black lung disease, if a patient has medical coverage under a workers' compensation program or the Federal Black Lung Program.

17 The U.S. Department of Labor has notified me that the coal company has agreed to pay for medical treatment for my black lung. How is this handled?

You will need to ask the coal company or its insurance carrier how and where both you and medical providers who might bill for you should submit medical claims. Usually, a medical benefit identification card is NOT issued by the coal company. If you need help, you may write or telephone the DCMWC District Office that handles your claim.

18 What if I have to pay the medical provider? How do I get reimbursed by the Federal Black Lung Program?

Present your Black Lung Benefits Identification Card to the medical provider whenever you seek treatment for your lung condition. A medical provider may bill directly, if already enrolled in the Federal Black Lung Program.

If you must pay for the medical services out-of-pocket then you may request reimbursement by completing the U.S. Department of Labor Medical Reimbursement Form, OWCP-915, as shown in Sample 2. Up to eight visits or services can be listed on this form. However, each line used MUST be filled in COMPLETELY. Therefore, statements such as "see attached" or "see attached receipts" are NOT acceptable, when used in any of the boxes on the form.

Send the completed Medical Reimbursement Form with your itemized paid statements or detailed receipts, securely attached, to:
FEDERAL BLACK LUNG PROGRAM
P.O. BOX 8302
LONDON, KY 40742-8302

Your detailed receipts or itemized statements MUST include the following information:

- Your full name;
- Name and address of the medical provider;
- Signature of the medical provider;
- Description of medical service performed;
- Date of service;
- Primary diagnosis or condition treated;
- Charge for each individual service; and,
- Total amount you paid.

Receipts and statements must be marked "patient paid" or "paid by patient" to show specifically who paid the charges.

"Paid" or "paid in full" are NOT acceptable.

A copy of the front and back of your canceled check may serve as proof of payment ONLY when accompanied by an itemized statement or copy of the doctor's ledger record. (See Sample 3.)

19 How do I get reimbursed for prescription drugs?

To obtain reimbursement, fill out a Medical Reimbursement Form, OWCP-915, as shown in Sample 4. Up to nine individual prescription drugs may be listed on this form. However, each line used MUST be filled in COMPLETELY. Therefore, statements such as "see attached" or "see attached receipts" are NOT acceptable when used in any of the boxes on the form.

Send the completed Medical Reimbursement Form, along with the original pharmacy receipts, securely attached, to:
FEDERAL BLACK LUNG PROGRAM
P.O. BOX 8302
LONDON, KY 40742-8302

These are acceptable receipts: a pharmacy bag or sticker, a computerized printout, or an itemized listing on the pharmacy's letterhead. These receipts MUST include:

- Your full name, address, and social security number;
- Name of the prescribing doctor;
- Name and address of the pharmacy;
- Prescription number;
- Amount prescribed - mg/ml or cc and total ml or cc per bottle for liquid medication, and/or mg per tablet and total number of tablets per prescription;
- Date purchased;
- Name of each drug;
- 11-digit National Drug Code (NDC) number for the prescribed medication;
- Charge actually paid for each drug less any discount (for example, senior citizen, coupon, etc.); a
- A statement, marked "patient paid" or "paid by patient," showing specifically who paid the charges. "Paid" or "paid in full" are NOT acceptable.

(See Sample 5.)

NOTE: If you send an itemized computerized printout, it MUST include all of the information already listed, as well as the PHARMACIST'S ORIGINAL SIGNATURE.

(See Sample 6.)

Your own itemized listing or cash register receipt is NOT considered proof of payment.

A copy of the front and back of your canceled check may serve as proof of payment, ONLY when accompanied by an itemized statement or pharmacist's ledger record.

If you need help getting or completing forms for the reimbursement of prescription drugs, please call toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (ET): 1-800-638-7072.

20 Can I be reimbursed for the cost of travel to get medical treatment related to my black lung?

Mileage costs for most travel to obtain medical treatment for your lung condition may be reimbursed. To get reimbursement, you must complete a Medical Travel Refund Request, OWCP-957, as shown in Sample 7. You may submit up to three trips on each form. However, you MUST have the MEDICAL PROVIDER, or an authorized representative, complete and SIGN block "H" for each visit.
Mail the completed Medical Travel Refund Request to:
FEDERAL BLACK LUNG PROGRAM
P.O. BOX 8302
LONDON, KY 40742-8302

NOTE: Overnight travel, related meals and lodging, and/or mileage that exceeds 150 miles round trip requires special prior approval from the DCMWC District Office. If you are not sure which office to contact, call the toll-free number, Mon.-Fri., 8:00 a.m.-8:00 p.m. (ET): 1-800-638-7072.
Travel to a pharmacy to pick up prescriptions is NOT covered.

Sample 7. Medical Travel Refund Request, OWCP-957

21 How much time will my reimbursement requests take to be processed?

Reimbursement requests which are submitted correctly will be processed by the Federal Black Lung Program within 30 days.

22 Will I be notified if the reimbursement requests I send in are going to be paid?

You will be notified by mail if your reimbursement requests will be paid or denied, through a form called a Remittance Voucher, as shown in Samples 8.a. and 8.b. This statement will contain the following information:

- The date of service;
- The amount of your reimbursement request;
- The amount you will be paid;
- A Remittance Voucher number at the top of the form. (This number will also appear on your check, if you receive a payment, so you can match payments with your reimbursement requests.); and,
- A "Message Code" which will explain why you were not paid for any portion of the reimbursement request.
- You will NOT receive a Remittance Voucher if your medical provider bills the Federal Black Lung Program directly.

23 What will happen if I have not submitted my reimbursement request forms or receipts correctly? Will I still receive a Remittance Voucher?

Any reimbursement request forms and receipts that need correction or additional information will be returned to you along with a letter explaining what is wrong or missing. It is very important that you correct and mail back these forms and receipts as soon as possible. You cannot be paid by the Federal Black Lung Program until you submit all forms and receipts properly. All corrected reimbursement forms and receipts should be mailed to:
FEDERAL BLACK LUNG PROGRAM
P.O. BOX 8302
LONDON, KY 40742-8302

If you need help correcting reimbursement requests which have been returned, you may call toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (ET): 1-800-638-7072.

24 Will a check come with the Remittance Voucher (RV)?

No, the check is always mailed separately. Checks are issued by the U.S. Treasury Department. The RV is sent from the Federal Black Lung Program office where your reimbursement requests are processed. The RV will usually arrive shortly after your check. Please remember to allow enough time (10 to 14 days) for both the check and the RV to arrive before making inquiries.

If you have questions about your RV, if you fail to receive either a check or an RV, or if your payment is incorrect and requires an adjustment, you may call toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (ET): 1-800-638-7072.

25 Whom should I notify if my mailing address changes?

Any changes in your mailing address should be reported to the DCMWC District Office with which your claim is filed. If you are not sure which office handles your claim, call toll free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (ET), and the operator will tell you whom to contact: 1-800-638-7072.

26 Should I keep copies of the bills that I send to the Federal Black Lung Program?

YES, if possible. Keeping a copy will give you a record of the reimbursement requests and receipts you have submitted.

27 Will I be notified when payments are made directly to my doctor, pharmacist, or other provider?

You will only receive Remittance Vouchers for reimbursements paid directly to you. However, once a year you will be mailed a record of all payments made on your behalf. You should review this record carefully.

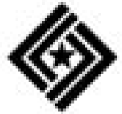
28 Whom do I call if I have questions about my medical bills; if I need reimbursement forms for treatment, prescriptions or travel; or, if my Black Lung Benefits Identification Card has been lost or destroyed?

You may call the Federal Black Lung Program's toll-free number, Mon.-Fri., 8:00 a.m.-8:00 p.m. (ET): 1-800-638-7072.

Sample 2. Medical Reimbursement Form, OWCP-915 (Doctor Visit)

Claim for Medical Reimbursement

U.S. Department of Labor
Employment Standards Administration
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. 1215-0193
Expires: 03/31/2007

PERSONAL INFORMATION

Name

SMITH (Last) CHARLES (First) P (M.I.)

OWCP File Number

999-99-9999

Address

319 JEFFERSON DR
Street/P.O. Box/Apt No.

TUNNELSPORT (City) PA (State) 16600 (Zip Code)

Telephone Number

(555)555-5555

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)

DOCTOR'S NAME

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM, DD, YY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
OFFICE VISIT	11/30/2004		65.00	☒	☐
OFFICE VISIT	12/15/2004		65.00	☒	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

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 Charles P. Smith Date 12/15/2004

Sample 3. Proof of Payment for Doctor Visit

PROOF OF PAYMENT

INSURANCE COPY-ATTACH THIS STATEMENT TO YOUR CLAIM FORM	☐ Cash ☐ Check	Charges	Payment	Adj.	Current Balance
			Credits		

DIAGNOSIS	Patient Name	Date of Service
	Patient Address	
	SSN	

DESCRIPTION-TYPE OF SERVICE

Office Visits	Code	Fee	Office Procedures	Code	Fee	Injection	Code	Fee
New Patient			120 Laryngoscopy	31525	____	300 Pneumovax	90732	____
100 Brief	90000	____	130 Intercostal Injection	64421	____	305 Inj. Decadron ____ mg IM	90890	____
102 Intermediate	90060	____	210 Spirometry Other	94010	____	Flu Shot	90742	____
103 Extended	90017	____	Holter Monitor			TOTAL PAID		
Established Patient			260 Recording	93275	____			
110 Brief	90040	____	262 Scanning	93276	____			
112 Intermediate	90060	____	264 Interpretation	93277	____			
113 Extended	90070	____						

JOHN C. WAZAB, M.D.
TUNNELSPORT MEDICAL CENTER
101 NORTH MAIN STREET
TUNNELSPORT, PA 16600

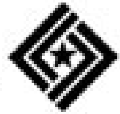
- Your full name
- Your address
- Your Social Security Number
- Name and address of medical provider
- Signature of medical provider
- Diagnosis or Condition Treated
- Date of Service
- Description of Service Performed
- Charges for each type of service
- Total amount you paid
- A statement showing specifically who paid the charges (PATIENT PAID or
- PAID BY PATIENT). "PAID" or "PAID IN FULL" are not acceptable.

If you need help getting or completing this form, please call toll-free, Mon.- Fri., 8:00 a.m.-8:00 p.m. (ET): 1-800-638-7072.

Sample 4. Medical Reimbursement Form, OWCP-915 (Prescription Drugs)

Claim for Medical Reimbursement

U.S. Department of Labor
Employment Standards Administration
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. 1215-0193
Expires: 03/31/2007

PERSONAL INFORMATION

Name

SMITH (Last) CHARLES (First) P (M.I.)

OWCP File Number

999-99-9999

Address

319 JEFFERSON DR
Street/P.O. Box/Apt No.

TUNNELSPORT (City) PA (State) 16600 (Zip Code)

Telephone Number

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)

DROG STORE NAME

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM, DD, YY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
TETRACYCLINE NDC 00182-0112-01	11/30/2004		35.00	☒	☐
THEODUR NDC 00085-0487-01	11/30/2004		72.50	☒	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Total Reimbursement
$ 107.50

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 *Charles P. Smith* Date *12/15/2004*

Sample 5. Pharmacy Bill Receipt

Tunnelsport Drug PH. 555-4587
345 Main Street, Tunnelsport, PA 16600
Smith, Charles 10/1/88
319 Jefferson Dr. Dr.J. Wazab
Tunnelsport, PA 16600 #90
999-99-9999
No. 105221
Tetracycline 250 MG RPh
00182-0112-01 = $6.04
THANK YOU VERY MUCH!!

Tunnelsport Drug PH. 555-4587
345 Main Street, Tunnelsport, PA 16600
Smith, Charles 10/1/88
319 Jefferson Dr. Dr.J. Wazab
Tunnelsport, PA 16600 #90
999-99-9999
No. 108854
THEO DUR 100 MG RPh
00085-0487-01 = $15.82
THANK YOU VERY MUCH!!

Prescription Drugs

Receipts can be the pharmacy bag or sticker, a computerized printout, or an itemized listing on the pharmacy's letterhead. These receipts must include:

- Your full name, address, and social security number
- Name of the prescribing doctor
- Name and address of the pharmacy
- Prescription number
- Amount prescribed-mg/ml or cc and total ml or cc per bottle for liquid medication, and/or mg per tablet and total number of tablets per prescription
- Date purchased
- Name of each drug
- 11-digit National Drug Code (NDC) number for the prescribed medication
- Charge actually paid for each drug less any discount (e.g., senior citizen or coupon)
- A statement showing specifically who paid the charges (PATIENT PAID or PAID BY PATIENT). "PAID" or "PAID IN FULL" are not acceptable.

Sample 6. Proof of Payment: Computerized Printout Pharmacy Receipt

Profile Print
Insurance Profile
Tunnelsport Drug Store
345 Main Street
Tunnelsport, PA 16600

for

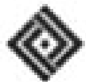
Smith, Charles P.
319 Jefferson Dr.
Tunnelsport, PA 16600
999-99-9999

RX#	Drug	DATE	QTY	PRICE	RPH
RX# 105221	Tetracycline 250 MG TABS Doctor: J. Wazab 00182-0112-01	10/1/88	90	6.04	ED
RX# 108854	Theo dur 100 MG TABS Doctor: J. Wazab 00085-0487-01	10/1/88	100	15.82	ED

Sample 7. Medical Travel Refund Request, OWCP-957

Medical Travel Refund Request

U.S. Department of Labor
Employment Standards Administration
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. 1215-0054
Expires: 06/30/2007

1. Claimant's Name (Last, First, MI.): SMITH CHARLES P

2. Case/Claim Number: 999-99-9999

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): 319 JEFFERSON DR 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: 11/30/2004
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, 15 NIGHT TRAIN LANE, TUNNELSPORT PA 16600
f. Total expense/cost: ☐ Taxi $ ☐ Bus/Train ☐ Tolls/Pkg 3.00 ☐ Lodging ☐ Meals 7.50 ☐ Other (Specify)
g. Private Auto Only Miles traveled 47
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 500-PNEUMOCONIOSIS
Frank Ryan, MD (Signature of Physician)
11/30/04 (Date Care Rendered)

6a. Date of Travel: 12/15/2004
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, 15 NIGHT TRAIN LANE, TUNNELSPORT PA 16600
f. Total expense/cost: ☐ Taxi $ ☐ Bus/Train ☐ Tolls/Pkg 3.00 ☐ Lodging ☐ Meals ☐ Other (Specify)
g. Private Auto Only Miles traveled 47
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 500-PNEUMOCONIOSIS
Frank Ryan, MD (Signature of Physician)
12/15/04 (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)
9. 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: Charles P. Smith   Date: 12/15/2004

Form OWCP-957
Rev. Aug 2003

Sample 8.a. Remittance Voucher (Front of Form)

```
1
DOLC8000-R0011
AS OF 04/01/04
0                                         R E M I T T A N C E   V O U C H E R                                         RUN DATE 03/27/04
OTO: CLAIMANT'S NAME          RV NO.: 123456 REFERENCE NO.: 1234567    DATE PAID: 04/01/04  CLAIMANT NUMBER: 123456789  PAGE:    1

OPROVIDER 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

 ORIGINAL BILLS:

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

                    * * * BILL TYPE: HCFA-1500                           * * * BILL STATUS: DENIED

 ORIGINAL BILLS:

 OCLAIMANT TRAVEL PAY-TO PROVIDER
                    0-04072-71-001-0002-00               163.78       0.00        0.00      0.00      0.00
                    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     E1399      1       105.65       0.00        0.00      0.00      0.00   999999991    103
   PREVIOUS-DATE-PAID: 03/11/04 CONFLICTING-TCN: 0-04054-71-001-0001-00
-R E M I T T A N C E   T O T A L S
 PAID ORIGINAL BILLS:           NUMBER OF BILLS   1         43.30                                   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:

      103 BILLED SERVICE DENIED.  DUPLICATE OF A SERVICE PREVIOUSLY PAID.                                       1
      172 NO VALID AMA CPT-4 OR OTHER PROCED CDE LISTED.
```

United States Treasury 15-51/000 P 788,294,725

Check No. 8888 88888888

04 01 04 48 PHILADELPHIA, PA

16150001 M1 OWCP MISC. 0109031113

Pay to the order of

BLACK LUNG CLAIMANT
100 MAIN STREET
ANYTOWN, USA 01234

$\$$*****43*30

VOID AFTER ONE YEAR

OWCP MED SVC PMNT. REMIT VCHR: 123456

Callouts: 1, 2, 3, 4, 5*, 6, 7, 8, 9, 10, 11

Sample 8.b. Remittance Advice (Back of Form)

Sample 8.b. Remittance Voucher
(Back of Form)

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. ACS 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 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 total bill denies.
10. Explanation of each EOB code is provided.
11. Remittance summary totals all bills covered under this RV with total amount billed and total amount paid for each category.

www.dol.gov

Employment Standards Administration | **U.S. Department of Labor** | Office of Workers' Compensation Programs