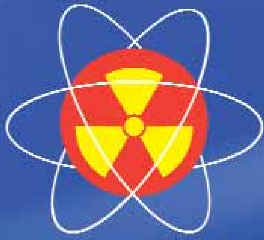

01/08

# Medical Benefits:

# Questions and Answers About the Energy Employees Occupational Illness Compensation Program

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Energy Employees
Occupational Illness Compensation

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## Introduction

As a qualified claimant under the U.S. Department of Labor's Energy Employees Occupational Illness Compensation Program (EEOICP), you are entitled to medical benefits to cover the reasonable cost of treatment for your covered condition(s). Medical providers (such as physicians, pharmacies, and hospitals) may bill the Department of Labor medical bill processing facility directly.

The questions in this booklet are those most often asked by EEOICP beneficiaries about:

- Medical benefits – covered and non-covered services; and

- Reimbursement for medical care and associated travel.

While this booklet gives you basic information about your medical treatment benefits, it is not intended to cover every possible exception or special case, and it does not have the effect of law or regulations.

For further information about special circumstances or individual cases, please call your claims examiner at the EEOICP District Office. A list of District Offices is on the last page of this booklet.

Q:
1, 2

### 1. Question: What costs are covered under the EEOICP?

Answer: The cost of medical treatment services and associated travel directly related to the treatment of your accepted condition(s) is covered as authorized under the EEOICP. These costs are payable at established rates for covered medical services. There is no deductible.

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

- Doctor's office visits, medical treatments, hospital visits, and consultations;
- Inpatient and outpatient hospital charges, including emergency room visits for the accepted conditions, diagnostic laboratory testing, and chest x-rays;
- Drugs prescribed by a doctor, both brand name and generic;
- Ambulance services; and
- Travel to the doctor, hospital, clinic, other medical facility, or pharmacy.

The following items require special approval for travel, treatment or purchase:

- Overnight travel, related meals and lodging, and/or mileage that exceeds 200 miles round trip;

- Treatment for consequential conditions;

- Special equipment as prescribed or recommended by the treating physician especially those items over $5,000.

Q: 1, 2

These require special approval from your claims examiner at the EEOICP District Office. A list of EEOICP District Offices is on the last page of this booklet.

Note: All durable medical equipment will be reimbursed at a predetermined rate according to the fee schedule aministered by the Office of Workers' Compensation Programs.

### 2. Question: Will I receive a Medical Benefits Identification Card?

Answer: Once you have been accepted for medical benefits under the EEOICP, you will receive a Medical Benefits Identification Card. On the front of the card, your name will be printed along with the accepted diagnosis for your condition. Also, it will be clearly printed that you have no co-pay or deductible expenses.

On the back of your Medical Benefits Identification Card, the address for medical billing purposes is printed, along with the toll-free customer service number for medical billing questions. Also on the back of your Medical Benefits Identification Card is a 10-digit access number that will allow you to check on the status of your medical bills on the internet (see page 20 and 21 of this booklet).

### 3. Question: What drugs are covered?

Answer: Most drugs prescribed by your doctor for the

Q:
3, 4,
5, 6

treatment of your covered condition(s) 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. (EST) at 1-866-272-2682.

You may purchase your prescriptions and then file for out-of-pocket reimbursement.

A new feature for pharmacy billing is the Point of Sale (POS). With this feature, you can present your Medical Benefits Identification Card to the pharmacist for your covered prescription(s). The pharmacist may then access the following website http://owcp.dol.acs-inc.com to verify **immediately** if a particular prescription(s) will
be paid or denied. You are able to pick up your prescription(s) without any out-of-pocket expense. By using POS, the pharmacist is not required to submit any billing paper work. The billing process is totally electronic. For more information regarding this feature, have your pharmacist call the toll-free number for billing questions at 1-866-272-2682, Mon.-Fri., 8:00 a.m.-8:00 p.m. (EST).

## 4. Question: What costs are not covered under the EEOICP?

Answer: The following are among the costs not covered under the EEOICP:

- Treatment of medical problems not related to your covered condition(s);
- Medical treatment for your spouse or other family members;

- Medicine that is not prescribed by a doctor;

and

- Personal services in the hospital, such as TV or telephone.

Q:
3, 4,
5, 6

**5. Question: What is the best way to get my medical bills paid?**

Answer: Whenever possible, have your doctor, hospital, pharmacy, and other medical providers bill the Department of Labor directly. If providers are enrolled in the EEOICP, the Department of Labor will pay them directly.

Your provider may also obtain enrollment information at the following website:
http://owcp.dol.acs-inc.com.

**6. Question: How can a medical provider get enrollment and billing information from the EEOICP?**

Answer: Medical providers can apply for enrollment at anytime. Those having questions about enrollment or billing may call the EEOICP toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (EST) at
1-866-272-2682.

**7. Question: Where should medical providers send bills related to the EEOICP?**

Answer: All EEOICP medical treatment bills should be sent to the following address:

Energy Employees Occupational Illness
Compensation Program
P.O. Box 8304
London, KY 40742-8304

Q:
7, 8, 9,
10, 11

### 8. Question: Does the medical provider need billing forms?

Answer: YES. The doctor, clinic, laboratory, ambulance, and nursing service should bill using the standard OWCP-1500 or HCFA-1500 form.

The pharmacy can bill using the Universal Pharmacy Billing form.

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

These are standard forms used throughout the medical community.

### 9. Question: When do I use my U.S. Department of Labor EEOICP Medical Benefits Identification Card?

Answer: You should present your Medical Benefits Identification Card whenever you seek treatment for your accepted condition(s). Showing a medical provider your card will identify you as
an EEOICP beneficiary and will help the medical provider determine the proper way to bill for services.

You will need to have your Social Security Number available when you present your card.

## 10. Question: What if the medical provider wants to bill Medicare or other insurance carriers instead of the EEOICP?

Answer: Other insurance carriers should not be billed first for treatment of your accepted condition(s), because EEOICP benefits represent primary coverage for beneficiaries.



## 11. Question: What if I have to pay the medical provider? How do I get reimbursed by the EEOICP?

Answer: We strongly encourage you to present your Medical Benefits Identification Card to the medical provider whenever you seek treatment for your accepted condition so that your medical provider may bill the Department of Labor directly.

If the medical provider will not bill directly, you may pay for the medical services out-of-pocket and then request reimbursement yourself.

To obtain a list of medical providers enrolled in our program, call the EEOICP toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (EST) at 1-866-272-2682.

To obtain reimbursement, complete the U.S. Department of Labor Claim for Medical Reimbursement Form, OWCP-915, as shown in Sample 1 on page 9. In addition to the OWCP-915, you must submit the provider's billing statement, receipt of payment by your provider and evidence of your method of payment. Acceptable evidence of payment include: a cash receipt, a copy of your canceled check (both

front and back) or a copy of your credit card receipt.

Up to eight visits or services can be listed on this form. However, each line used must be filled in completely. Statements such as “see attached” or “see attached receipts” are **not acceptable** when used in any of the boxes on the form.
All medical bills submitted to the EEOICP are subject to a fee schedule.

Q: 11
S: 1

Send the completed Claim for Medical Reimbursement Form with your itemized paid statement or detailed receipts, securely
attached, to:

Energy Employees Occupational Illness
Compensation Program
P.O. Box 8304
London, KY 40742-8304

**Claim for Medical Reimbursement**

Reset | Print

**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: 03/31/2010

**PERSONAL INFORMATION**

Name: Smith (Last) Charles (First) P (M.I.)

OWCP File Number: 999-99-9999

Address: 319 Jefferson Drive (Street/P.O. Box/Apt No.)

Telephone Number: 814-999-0124

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

**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)

| Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply) | Date of Service (MM, DD, YY) From | Date of Service (MM, DD, YY) To | Amount Paid by Claimant | Have you included Proof of Payment for each item? YES | NO |
|---|---|---|---|---|---|
| Office Visit | 09/27/01 | 09/27/01 | $35.00 | ☒ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |

**Total Reimbursement** $ $35.00

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 Smith Date: 10/01/2001

Form OWCP-915
August 2006

Sample 1 – Claim for Medical Reimbursement (Doctor Visit)

Q: 11
S: 1

## 12. Question: How do I get reimbursed for prescription drugs?

Answer: We strongly encourage you to present your EEOICP Medical Benefits Identification Card at the pharmacy when you have a prescription filled for your accepted condition. If the pharmacy is enrolled as a medical provider, the EEOICP may be billed directly, or use Point of Sale. If the pharmacy will not bill the Department of Labor directly, you must pay for the medicine out-of-pocket and then submit for reimbursement yourself.

Q: 12

To obtain reimbursement, complete the Claim for Medical Reimbursement Form, OWCP-915, as shown in Sample 2 on page 13. Up to eight 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 Claim for Medical Reimbursement Form, along with the original pharmacy receipts securely attached, to:

Energy Employees Occupational Illness Compensation Program
P.O. Box 8304
London, KY 40742-8304

Acceptable receipts include: 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 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); and
- 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 3 on page 14.)

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 4 on page 15.)
Your own itemized listing or cash register receipt is not considered proof of payment.

Q: 12

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 drugs, please call toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (EST) at 1-866-272-2682.

Q: 12
S: 2

**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: 03/31/2010

**PERSONAL INFORMATION**

Name

Smith (Last) Charles (First) P (M.I.)

OWCP File Number

999-99-9999

Address

319 Jefferson Drive
Street/P.O. Box/Apt No.

Tunnelsport, (City) PA (State) 16600 (Zip Code)

Telephone Number

814-999-0124

**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)

Tunnelsport Drug

| Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply) | Date of Service (MM, DD, YY) From | Date of Service (MM, DD, YY) To | Amount Paid by Claimant | Have you included Proof of Payment for each item? YES | NO |
|---|---|---|---|---|---|
| RX9166 Lasix | 09/27/01 | 09/27/01 | $ 7.99 | ☒ | ☐ |
| RX9167 Theophylline | 09/27/01 | 09/27/01 | $10.00 | ☒ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | **Total Reimbursement** $ 17.99 | | |

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 10/01/2001

**Form OWCP-915**
August 2006

Sample 2 – Claim for Medical Reimbursement (Prescription Drugs)

Q: 12
S: 2

| | |
|---|---|
| Tunnelsport Drug<br>345 Main Street, Tunnelsport, PA 16600<br>(814) 999-0123 | |
| Smith, Charles P.<br>319 Jefferson Drive<br>Tunnelsport, PA 16600<br>999-99-9999 | Date: 09/27/2001<br>Dr. J.C. Wazab |
| RX 9166, Refill 1 time, 15 days<br>Lasix 20 MG Tab SA<br>NDC: 00039-0067-10<br>QTY: 15 | **Patient Paid** RPh<br>$7.99 |
| Thank You Very Much! | |

| | |
|---|---|
| Tunnelsport Drug<br>345 Main Street, Tunnelsport, PA 16600<br>(814) 999-0123 | |
| Smith, Charles P.<br>319 Jefferson Drive<br>Tunnelsport, PA 16600<br>999-99-9999 | Date: 09/27/2001<br>Dr. J.C. Wazab |
| RX 9167, Refill 1 time, 60 days<br>Theophylline 300 MG Tab SA<br>NDC: 59930-1670-03<br>QTY: 60 | **Patient Paid** RPh<br>$10.00 |
| Thank You Very Much! | |

S: 3, 4

Sample 3 – Pharmacy Bill 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# | | | DATE | QTY | PRICE | RPH |
|---|---|---|---|---|---|---|
| RX# | 9166 | Lasix 20 MG TABS<br>Doctor: J. Wazab<br>00039-0067-10 | 09/27/2001 | 15 | Patient Paid<br>7.99 | ED |
| RX# | 9167 | Theophylline 300 MG TABS<br>Doctor: J. Wazab<br>59930-1670-03 | 09/27/2001 | 60 | Patient Paid<br>10.00 | ED |

**Note: Pharmacist Signature needed.**

Sample 4 – Proof of Payment

S: 3, 4

### 13. Question: Can I be reimbursed for the cost of travel to get medical treatment or prescriptions related to my accepted condition?

Answer: Mileage costs for most travel to obtain medical treatment or prescriptions for your accepted condition may be reimbursed. To receive reimbursement for mileage, you must complete a Medical Travel Refund Request,
OWCP-957, as shown in Sample 5 on page 17.
You may submit up to three trips on each form.

Mail the completed Medical Travel Refund Request to:

Energy Employees Occupational Illness Compensation Program
P.O. Box 8304
London, KY 40742-8304

Note: Overnight travel, related meals and lodging, and/or mileage that exceeds 200 miles round trip requires special approval from
your claims examiner in the EEOICP District Office prior to travel. A list of toll-free numbers for the District Offices is on the last page of this booklet.

Q: 13, 14
S: 5

Travel to a pharmacy to pick up prescribed drugs is covered. You must have the pharmacy name, city, state, and zip code indicated in block "E" for each visit and your signature is required in
block 8 of Form 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: 08/31/2010

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 Dive, 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: 09/27/01

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 Drug Store
345 Main Street
Tunnelsport, PA 16600

f. Total expense/cost: ☐ Taxi $ ☐ Bus/Train ☐ Tolls/Pkg ☐ Lodging ☐ Meals ☐ Other (Specify)

g. Private Auto Only Miles traveled 23

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)

6a. 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)

g. 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)

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)

g. 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 Smith

Date: 10/01/2001

Form OWCP-957
Rev. Aug 2003

Sample 5 – Medical Travel Refund Request

Q: 13, 14
S: 5

## 14. Question: How much time will my reimbursement requests take to be processed?

Answer: Reimbursement requests which are submitted correctly will be processed by the EEOICP within 30 days.

## 15. Question: Will I be notified if the reimbursement requests I send in are going to be paid?

Answer: YES. You will be notified by mail if your reimbursement requests will be paid or denied, through a form called a Remittance Voucher (RV), as shown in Sample 6 on page 19.

This statement will contain the following information:

- The date of service;
- The amount of your reimbursement request;
- The amount you will be paid;
- An RV number on the top left-hand side 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
- Explanation of Benefits Codes (EOB Codes) will explain why you were not paid for any portion of the reimbursement request.

Q: 15, 16
S: 6

You will not receive a Remittance Voucher if your medical provider bills the Department of Labor directly.

## HOW TO READ YOUR REMITTANCE VOUCHER

Please retain a copy of your remittance voucher to compare against your check.
Please retain a copy of your check to compare against your remittance voucher.

Sample 6 – Remittance Voucher (Front of Form)

Q: 15, 16
S: 6

### 16. Question: What will happen if I have not submitted my reimbursement request forms or receipts correctly? Will I still receive a Remittance Voucher?

Answer: If you have any reimbursement request forms

and receipts that need correction or additional information, a customer service representative will attempt to reach you by phone to obtain the correct or additional information. If the customer service representative is unable to reach you by phone, your 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 EEOICP until you submit all forms and receipts properly. All corrected reimbursement forms and receipts should be mailed to:

Energy Employees Occupational Illness Compensation Program
P.O. Box 8304
London, KY 40742-8304

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. (EST) at
1-866-272-2682.

### 17. Question: Will a check come with the Remittance Voucher?

Q: 16, 17, 18, 19, 20

Answer: NO. The check is always mailed separately. Checks are issued by the U.S. Department of Treasury. The Remittance Voucher is sent from the EEOICP office in Dallas, Texas, where your reimbursement requests are processed. The Remittance Voucher should arrive shortly before your check. Please remember to allow enough time (10 to 14 days) for both the check and the Remittance Voucher to arrive before making inquiries.

If you have questions about your Remittance Voucher, if you fail to receive either a check or a Remittance Voucher, 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. (EST) at 1-866-272-2682.

### 18. Question: Whom should I notify if my mailing address changes?

**Answer:** Any changes in your mailing address should be reported in writing to the EEOICP District Office with which your claim is filed.
A list of the District Offices is on the last page of this booklet.

### 19. Question: Should I keep copies of the bills that I send to the EEOICP?

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

### 20. Question: 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 EEOICP Medical Benefits Identification Card has been lost or destroyed?

**Answer:** You may call the EEOICP toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (EST) at 1-866-272-2682.



In addition, you may check the status of any medical bill(s) that you have submitted for payment by accessing the ACS Web Bill Processing Portal on the internet. The internet address is http://owcp.dol.acs-inc.com. In order to log on to the system, you will be required to

enter the following three (3) fields:

1. Case File Number—this is your social security number
2. Card ID Number—this is the 10-digit number printed on the back of your Medical Benefits Identification Card (MBIC)
3. Date of Birth

You may also download forms from this website.

### 21. Question: What do I do if I have additional questions?

**Answer:** You may call the EEOICP toll-free, Mon.-Fri., 8:00 a.m.-8:00 p.m. (EST) at 1-866-272-2682.

## EEOICP DISTRICT OFFICE LOCATIONS

### District Office 1 – Jacksonville, Florida

(Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee)

U.S. Department of Labor, DEEOIC
400 West Bay Street, Suite 722
Jacksonville, FL 32202
(877) 336-4272 (Toll Free)

### District Office 2 – Cleveland, Ohio

(Connecticut, Delaware, District of Columbia, Illinois, Indiana, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Puerto Rico, Rhode Island, Vermont, Virgin Islands, Virginia, West Virginia and Wisconsin)

U.S. Department of Labor, DEEOIC
1001 Lakeside Avenue, Suite 350
Cleveland, OH 44114
(888) 859-7211 (Toll Free)

Q: 20, 21 District Offices

## District Office 3 – Denver, Colorado

(Arkansas, Colorado, Kansas, Louisiana, Missouri, Montana, Nebraska, North Dakota, Oklahoma, South Dakota, Texas, Utah, Wyoming and all claims from RECA Section 5 awardees)

U.S. Department of Labor, DEEOIC
1999 Broadway, Suite 1120
P.O. Box 46550
Denver, CO 80201-6550
(888) 805-3389 (Toll Free)

## District Office 4 – Seattle, Washington

(Alaska, Arizona, California, Idaho, Hawaii, Marshall Islands, Nevada, New Mexico, Oregon and Washington)

U.S. Department of Labor, DEEOIC
719 2nd Avenue, Suite 601
Seattle, WA 98104
(888) 805-3401 (Toll Free)