MEDICAL TREATMENT AND BILLS

The Federal Employees' Compensation Act authorizes medical services for treatment of any condition which is causally related to factors of Federal employment. No limit is imposed on the amount of medical expenses or the length of time for which they are paid, as long as the charges represent the reasonable and customary fees for the services involved and the need for the treatment can be shown. Federal employees are entitled to all services, appliances, and supplies prescribed or recommended by qualified physicians which, in the opinion of OWCP, are likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation. Medical care includes examination, treatment, and related services such as medications and hospitalization, as well as transportation needed to secure these services. Preventive care may not be authorized, however.

OWCP will pay for or reimburse only those services rendered for work-related injuries. Documentation usually takes the form of a report or clinical notes from the physician, or a copy of the discharge summary from a hospital.

Most providers must submit their bills on the American Medical Association (AMA) Standard Health Insurance Claim Form (HCFA-1500). A version of the form which includes instructions for submitting bills to OWCP carries the form number OWCP-1500. In some states the local version of the form may not be designated "HCFA-1500" or may differ from the standard AMA form in other ways. Such local variations are acceptable if they are otherwise complete.

The following providers are *required* to use Form HCFA-1500 to submit bills: physicians; nursing services; laboratories and X-ray facilities; chiropractors; therapists; and suppliers of medical equipment and goods. Dentists are *encouraged* to use the HCFA-1500; however, they may use the standard ADA billing form instead. Pharmacies must use the Universal Claim Form. Hospitals must use Form UB-92, and nursing homes are encouraged to use these forms as well. Bills rendered by ambulance services may be submitted on billhead, as may bills from foreign providers. Veterans Administration facilities may submit bills using Form VA-10-9014.

To be accepted for payment, the bill must include the following information at a minimum:

(1) Employee's name;
(2) Employee's Claim number
(3) Provider's name and address;
(4) Diagnosis;
(5) Itemized list of services, with charges; and
(6) Tax identification number (the provider's Employer Identification Number or Social Security Number).
(7) Providers (excluding Pharmacy) must bill with their ACS OWCP provider number in box 33 of OWCP-1500 or box 51 of OWCP-04.

All bills must be sufficiently itemized to allow for evaluation of the charges. The Current Procedural Terminology (CPT) code for each medical, surgical, X-ray or laboratory service should be shown on the HCFA-1500, and bills should state the dates on which the services or supplies were furnished. Individual dates are not necessary if the bill is for repetitive charges over a period of time. In such cases the billing should show the beginning and ending dates of service, and the number of units of service.

No bill will be paid unless it is submitted to OWCP on or before December 31st of the year following the calendar year in which the expense was incurred or the claim (or specific condition, as appropriate) was first accepted as compensable by OWCP, whichever is later.

Unless the amount involved is minor, OWCP will advise the payee fully of any adjustments to the bill by letter which explains the amount of the deletion or reduction, the particular charge affected, the reasons for the action, and the amount for which the bill is being approved. If a bill is reduced because the charges exceed the amount allowed by the OWCP fee schedule, a separate notice will be issued.

CHIROPRACTORS

Under the Federal Employees' Compensation Act (FECA), the services of chiropractors may be reimbursed only for treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. The term "subluxation" is defined as an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae anatomically which must be demonstrable on any X-ray film to individuals trained in the reading of X-rays. Chiropractors may interpret their own X-rays, and if a subluxation is diagnosed, OWCP will accept the chiropractor's assessment of any disability caused by it. Chiropractors may provide physical therapy services as prescribed or authorized by the injured worker's treating physician. Since a chiropractor is not an extremity expert and there is no schedule award payable for the spine under FECA, a chiropractor's opinion regarding a permanent impairment of no probative medical value.

Fiscal Agent Services
PO Box 14600
Tallahassee, FL 32317-4600

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

June 16, 2006

Dear Provider:

Thank you for your participation as a provider for the U.S. Department of Labor, Office of Workers' Compensation Programs (OWCP).

The OWCP administers the Federal Employees' Compensation Act (FECA), the Coal Mine Workers' Compensation Program (DCMWC), and the Energy Employees Occupational Illness Compensation Program (EEOICPA).

OWCP has contracted with Affiliated Computer Services (ACS) to provide medical bill processing services to the three programs. As part of their benefit structure, these three programs reimburse both, medical and non-medical providers for services rendered for the care and treatment of a claimant's compensable condition.

To process your bills, each provider MUST BE ENROLLED with ACS. Please complete the enclosed provider enrollment form so that a provider I.D. number can be assigned to you. **Effective July 26, 1996 the Debt Collection Improvement Act of 1996 MANDATES that payments made by the Federal Government be sent by electronic funds transfer (EFT) therefore, an enrollment form for EFT is also enclosed. A Remittance Advice listing all bills paid on each EFT transaction will continue to be sent to your mailing address.**

In addition to the provider and EFT enrollment forms enclosed are instructions for completing the enrollment form, a list of provider types, a list of provider specialty codes and an Electronic Data Interchange (EDI) form should you choose to bill electronically.

Please send the completed package to:

Affiliated Computer Services (ACS)
Enrollment Unit
Department of Labor
PO Box 14600
Tallahassee, FL 32317-4600

You MUST submit a copy of your license along with the enrollment application.

Once your enrollment package has been processed, you will be notified by mail in approximately two weeks. During the transitional period, please continue to submit your bills to:

US Department of Labor
OWCP
PO Box 8300
London, KY 40742-8300

Please do not hesitate to contact us at 1-850-558-1818 Monday through Friday from 8:00 am to 8:00 pm Eastern Standard Time, if you have any questions on this material.

Provider Enrollment Form

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

OMB Number 1215-0137
Expires: 03/31/2007

Please refer to instructions for completing this form.

Provider Number	Effective Date

FOR DOL USE ONLY

1. Are you applying for a new enrollment or updating your record? ☐ New enrollment ☐ Update
   If update, enter Provider Number or EIN:

2. What is the earliest date that you treated a participant in any OWCP program?

Practice Information

3. Practice Name	4. Address		
5. City		6. State	7. Zip (9 digits)
8. Telephone		9. FAX	

10. Type of Practice
    a. ☐ Individual b. ☐ Facility (For Individual or Facility, complete indicated sections below)
    c. ☐ Group (Please see reverse for completion of group enrollment)

Provider Type (Individual or Facility)

11a. Provider Type Code	11b. Provider Type

11c. If you select "Other Provider" (96) or Non-Medical Vendor (53), please explain:

12. Tax ID: EIN	SSN

13. Medicare Number (required for hospitals only)

License and Certification (Individual for M.D. and D.O. only)

14a. Name	14b. License #/ State	14c. Current Lic Expiration Date	14d. Specialty Code(s)	14e. Certification Expiration Date

15. UMWA Health & Retirement Funds Member Number, if applicable:

Billing Address—indicate "same" if identical to Practice Address.

16a. Address

16b. City	16c. State	16d. Zip (9 digits)

17. ☐ I have completed a form for Electronic Funds Transfer (EFT).

18. ☐ I am interested in billing electronically

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.

Signature (Provider or Representative and Title)	Date

Group Provider Enrollment — #10c

For group practice enrollment, please enter the following information for **each professional** who will provide services under the group EIN. Select from the attached list the Provider Type code that most closely describes the service(s) that the professional provides. Attach separate sheet for additional entries if necessary.

Name	SSN #	Prov Type Code	License #/ State	Current Lic# Exp Date	Specialty Code(s)	Certification Exp Date

Please return this completed form to the appropriate program at the following address to prevent a delay in the processing of your bills.

For Federal Employees' Compensation Act (FECA) Program:	*For Black Lung Program:*	*For Energy Program:*	*For Longshore Program:*
ACS P.O. Box 14600 Tallahassee, FL 32317-4600	DOL Black Lung Program P.O. Box 13200 Tallahassee, FL 32317-3200	DOL Energy Program P.O. Box 13400 Tallahassee, FL 32317-3400	Division of Longshore and Harbor Workers' Compensation 200 Constitution Avenue, Room C-4315 Washington, D.C. 20210
If you have any questions regarding the completion of the form, please call Toll Free: 1-866-335-8319	If you have any questions regarding the completion of the form, please call Toll Free: 1-800-638-7072	If you have any questions regarding the completion of the form, please call Toll Free: 1-866-272-2682	If you have any questions regarding the completion of the form, please call; 1-202-693-0925

Privacy Act Statement

(1) Collection of this information is authorized by the Federal Employees' Compensation Act (20 CFR 10.801), the Black Lung Benefits Act (20 CFR 725.704 and 725.705), the Energy Employees Occupational Illness Compensation Program Act of 2000 (20 CFR 30.701), and the Longshore and Harbor Workers' Compensation Act (20 CFR 702.503). (2) The information collected on this form will be used to ensure accurate medical provider information for payment of medical and vocational rehabilitation bills. (3) Disclosure of your Social Security Number and completion of this form is voluntary; however, failure to provide the information may result in bill payment delays. (4) This information may be furnished to data processing contractors, to the Department of Labor and to the IRS in accordance with law. (5) Furnishing all requested information will facilitate accurate and timely payment for services to the provider.

Public Burden Statement

We estimate that it will take an average of 8 minutes to complete this information collection, including time for reviewing the instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this collection, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE ABOVE ADDRESS

Provider Enrollment Form (Instructions)

A brief description of each data element is listed below. Be sure to sign and date the form when you submit it. For further information contact ACS at 1-866-335-8319 (toll free).

Block 1	Indicate whether this form is being used for a new enrollment, or to update an existing enrollment record. If the form is being submitted to update your record, enter your Provider Number or EIN.
Block 2	Indicate earliest date you treated any OWCP beneficiary.
Block 3	Type or print your practice name.
Block 4	Type or print your practice street address.
Block 5	Type or print your practice city.
Block 6	Type or print your practice state.
Block 7	Type or print your practice zip code (all nine digits).
Block 8	Type or print your practice telephone number.
Block 9	Type or print your practice FAX number (if applicable).
Block 10	Check your practice type—"a" for individual practice, "b" for a facility, or "c" for a group practice. If you checked "c" (group practice), fill out the appropriate parts of Block 10c on the reverse of the form for each professional that will be providing services under the group Provider Number (name, Social Security number, provider type code from list below, license number and State, expiration date of current license, specialty code or codes from the list below, and the date any certification expires). Continue on a separate sheet if necessary.
Block 11a	If you checked "a" or "b" (individual practice or facility) in Block 10, type or print your "Provider Type" code from the list below.
Block 11b	If you checked "a" or "b" (individual practice or facility) in Block 10, type or print the "Provider Type" that corresponds with the code you entered in Block 11a.
Block 11c	If you checked "a" or "b" (individual practice or facility) in Block 10 and selected "Other Provider" (code 96) or "Non-Medical Vendor (code 53), please explain why you are enrolling.
Block 12	If you checked "a" or "b" (individual practice or facility) in Block 10, type or print your Social Security number and/or your EIN, as appropriate.
Block 13	If you checked "a" or "b" (individual practice or facility) in Block 10, type or print your Medicare number (for hospitals only).
Block 14a	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your name.
Block 14b	If you checked "a" (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your license number and State.

Block 14c If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print the expiration date of your current license.

Block 14d If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your specialty code or codes from the list below.

Block 14e If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print the expiration date of any certification you currently hold.

Block 15 If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your United Mine Workers of America (UMWA) number, if any.

Block 16a If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your billing street address. This is where your Remittance Advices and paper checks will be sent. If this address is identical to your billing address above in Blocks 4 through 7, indicate “same” and skip Blocks 16b, 16c and 16d.

Block 16b If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your billing city.

Block 16c If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your billing State.

Block 16d If you checked “a” (individual practice) in Block 10 and you are an M.D. or a D.O, type or print your billing zip code (all nine digits).

Block 17 Indicate whether you have also completed a form for Electronic Funds Transfer (EFT).

Block 18 Indicate whether you are interested in billing electronically.

* * * * * * *

Provider Type Codes (Blocks 10c, 11a and 11b)

01 General Hospital
02 Special Hospital/Outpatient Rehabilitation Facility
03 Psychiatric Hospital
05 Community Mental Health Center
19 End Stage Renal Hospital
20 Pharmacy
25 Physician (MD)
26 Physician (DO)
27 Podiatrist
28 Chiropractor
29 Physician Assistant
30 Advanced Registered Nurse Practitioner (ARNP)
31 CRNA
32 Psychologist
34 Licensed Midwife
35 Dentist
36 Registered Nurse (RN)
37 Licensed Practical Nurse (LPN)
38 Nursing Attendant

39 Massage Therapist
40 Ambulance
41 Contract Nurse
42 Air/Water Ambulance Company
43 Taxi
44 Public Transportation
45 Private Transportation
46 Hospice
50 Independent Laboratory
51 Portable X-Ray Company
52 Alternative Medicine
53 Non-Medical Vendor
54 Prosthetics/Orthotics
55 Vocational Rehabilitation (Training, Tuition and Schools)
56 Vocational Rehabilitation Counselor
57 Rehabilitation Maintenance
58 Assisted Re-employment
59 Relocation Expenses
60 Audiologist/Speech Pathologist
61 Second Opinion Contractor
62 Optometrist
63 Optician
65 Home Health Agency
66 Rural Health Clinic
68 Federally Qualified Health Center
69 Birthing Center
70 HMO or PHP
71 Physical Therapist
72 Occupational Therapist
73 Pulmonary Rehabilitation
74 Outpatient Renal Dialysis Facility
75 Medical Supplies/Durable Medical Equipment (DME)
76 Case Management Agency
77 Social Worker
78 Blood Bank
79 Alternative Payee
80 Pay-to-Intermediary
88 Ambulatory Surgery Center
89 Federal Facility (VA Hospital)
90 Skilled Nursing Facility (SNF)—Medicare Certified
91 Skilled Nursing Facility (SNF)—Non-Medicare Certified
92 Intermediate Care Facility (ICF)
93 Rural Hospital Swing Bed
94 Boarding House
95 Insurance Company (Third Party Carriers)
96 Other Provider
97 Billing Agent
98 Lien holder

* * * * * * *

Provider Specialty Codes (Blocks 10cd and 14d)

01	Adolescent Medicine
02	Allergy
03	Anesthesiology
04	Cardiovascular Disease
05	Dermatology
06	Diabetes
07	Emergency Medicine
08	Endocrine Medicine
09	Family Practice
10	Gastroenterology
11	General Practice
12	Preventative Medicine
13	Geriatrics
14	Gynecology
15	Hematology
16	Immunology
17	Infectious Diseases
18	Internal Medicine
20	Neoplastic Diseases
21	Nephrology
22	Neurology
24	Neuropathology
25	Nutrition
26	Obstetrics
27	Obstetrics and Gynecology
28	Occupational Medicine
29	Oncology
30	Ophthalmology
31	Otolaryngology
32	Pathology
33	Pathology, clinical
34	Pathology, forensic
40	Pharmacology
41	Physical medicine and rehab
42	Psychiatry
44	Psychoanalysis
45	Public Health
46	Pulmonary diseases
47	Radiology
48	Diagnostic radiology
50	Therapeutic radiology
51	Rheumatology
52	Abdominal surgery
53	Cardiovascular surgery
54	Colon and rectal surgery
55	General surgery
56	Hand surgery
57	Neurological surgery
58	Orthopedic surgery
60	Plastic surgery
61	Thoracic surgery
62	Traumatic surgery
63	Urological surgery
64	Other physician specialty
65	Maternal fetal medicine
70	Adult, dentures only
71	General dentist
72	Oral surgeon, dentist
74	Other dentist
75	Adult primary care nurse practitioner
76	Clinical nurse specialist
77	College nurse practitioner
78	Diabetic nurse practitioner
80	Family/Emergency nurse
82	Geriatric nurse practitioner
84	Nurse anesthesiologist
85	Nurse midwife
86	OB/GYN nurse practitioner
88	Orthodontist
90	Occupational therapist
91	Physical therapist
92	Speech therapist
93	Respiratory therapist
95	Aged/disable waiver
96	Develop services waiver
97	Channeling waiver
98	Comm supp living arrangement
99	Other

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ____ . __ 3. ____ . __ 2. ____ . __ 4. ____ . __	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#		

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG, FECA AND EEOICPA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung, FECA and EEOICPA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA, BLACK LUNG AND EEOICPA)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional services by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations. For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, BLACK LUNG AND EEOICPA INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, Black Lung and EEOICPA programs. Authority to collect information is in sections 205(a), 1862, 1872 and 1874 of the Social Security Act, as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101; 41 CFR 101 et seq. and 10 USC 1079 and 1086; 5 USC 8101 et seq.; 30 USC 901 et seq.; 38 USC 613; E.O. 9397; and 42 USC 7384d, 20 CFR 30.11 and E.O. 13179. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor systems DOL/GOVT-1, DOL/ESA-5, DOL/ESA-6, DOL/ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOL/ESA-49 and DOL/ESA-50 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Departments of Veterans Affairs, Health and Human Services and/or Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services received or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State law.

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a												A
b												B
												C

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT	
	a	.		.		.	a
	b	.		.		.	b
	c	.		.		.	c
	d	.		.		.	d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1						.	.		1
2						.	.		2
3						.	.		3
4						.	.		4
5						.	.		5
6						.	.		6
7						.	.		7
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14						.	.		14
15						.	.		15
16						.	.		16
17						.	.		17
18						.	.		18
19						.	.		19
20						.	.		20
21						.	.		21
22						.	.		22
23						.	.		23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
A					.	.		A
B					.	.		B
C					.	.		C
57		**DUE FROM PATIENT ▶**			.	.		

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	
A					A
B					B
C					C

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		

	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID	
	C		D		E		A	a
								b
							OTHER PHYS. ID	a
							B	b

a	84 REMARKS	85 PROVIDER REPRESENTATIVE X	86 DATE
b			
c			
d			

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.
   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Instructions for Completing OWCP-92 Uniform Billing Form For Medical Services Provided Under the FEDERAL EMPLOYEES' COMPENSATION ACT (FECA), the BLACK LUNG BENEFITS ACT (BLBA), and the ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT of 2000 (EEOICPA)

GENERAL INFORMATION—FECA AND EEOICPA CLAIMANTS: Claims filed under FECA (5 USC 8101 et seq.) are for employment-related illness or injury. Claims filed under EEOICPA (42 USC 7384 et seq.) are for occupational illnesses defined under that Act. Benefits provided under these statutes include Inpatient/outpatient hospital services, ambulatory surgical care, chemotherapy treatment services, and other non-professional medical services for covered injuries or occupational illnesses. Services provided by skilled nursing facilities, nursing homes and hospices (including medications and other services such as oxygen and respiratory services), as well as personal care services provided by a home health aide, licensed practical nurse or similarly trained individual, may also be provided.

FEES: The Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for payment of all reasonable charges stemming from covered medical services provided to claimants eligible under FECA and EEOICPA. OWCP uses a condition-specific fee schedule based on the Prospective Payment System devised by the Centers for Medicare and Medicaid Services (CMS) and other tests to determine reasonableness. Schedule limitations are applied through an automated billing system that is based on the identification of procedures as defined in the AMA's Current Procedural Terminology (CPT), Revenue Center codes and Diagnosis-Related Group (DRG) codes; therefore, use of correct codes and modifier(s) is required. Incorrect coding will result in inappropriate or delayed payment. For specific information about schedule limits, call the Dept. of Labor's Federal Employees' Compensation office or Energy Employees Occupational Illness Compensation office that services your area.

ITEMIZED BILLS AND TREATMENT PLANS: All forms submitted for inpatient hospital services must be accompanied by an itemized billing statement and an admission/discharge summary. Forms submitted for hospice services or for personal care services provided in the home must be accompanied by a plan of care and treatment.

GENERAL INFORMATION—BLBA CLAIMANTS: The BLBA (30 USC 901 et seq.) provides medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the BLBA. For specific information about reimbursable services, call the Department of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF INFORMATION

(PRIVACY ACT STATEMENT)

OWCP is authorized by 5 USC 8101 et seq., 30 USC 901 et seq., and 42 USC 7384d to collect information needed to administer the FECA, BLBA and EEOICPA. The information collected is used to identify the eligibility of the claimant for benefits, and to determine coverage of services provided. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) received or the amount charged will prevent payment of the claim. Failure to supply the claim number or required codes will delay payment or may result in rejection of the bill because of incomplete information.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in Department of Labor systems DOL/GOVT-1, DOL/ESA-5, DOL/ESA-6, DOL/ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOL/ESA-49 and DOL/ESA-50 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

SIGNATURE OF PROVIDER: Your signature in Block 85 indicates your agreement to accept the charge determination of OWCP on covered services as payment in full, and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed). Your signature in Block 85 also indicates that the services shown on this form were provided, and that the billing information submitted is both complete and accurate. Finally, your signature indicates that you understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

FORM SUBMISSION

FECA: Send all forms for FECA to the DFEC Central Mailroom, P.O. Box 8300, London, KY 40742, unless otherwise instructed.
BLBA: Send all forms for BLBA to the Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828, unless otherwise instructed.
EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 727, Lanham-Seabrook, MD 20703-0727, unless otherwise instructed.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

INSTRUCTIONS FOR COMPLETING THE FORM: A brief description of each data element and its applicability to requirements under FECA, BLBA and EEOICPA are listed below. For further information contact OWCP.

Block 1 Type or print complete provider name, street address, city, state and zip code. Also include area code and phone number.
Block 2 Blank field.
Block 3 Not required.
Block 4 Type of bill classification using appropriate three-digit code: 1st position indicates type of facility, 2nd position indicates type of care, 3rd position indicates billing sequence..
Block 5 Type or print Federal tax I.D. assigned for tax reporting purposes.
Block 6 Type or print dates for the full ranges of services being invoiced (period from/through using MM/DD/YY).
Block 7 Type or print number of covered days.
Block 8 Not required.
Block 9 Not required.
Block 10 Not required.
Block 11 Blank field.
Block 12 Type or print patient's name. Use a comma or space to separate the last and first names, do not use titles such as Mr. or Mrs., and do not leave a space before a prefix to a last name. If last name is hyphenated, both names should be capitalized, and a space should separate a last name and any suffix. For EEOICPA, type or print name as it appears on the Medical Benefits Identification Card.
Block 13 Type or print complete mailing address of patient.
Block 14 Type or print month, year, and day of patient's birth (MM/DD/YY).
Block 15 Type or print sex of patient, using M or F only.
Block 16 Not required.
Block 17 Type or print month, day, and year (MM/DD/YY) of admission.
Block 18 Enter the code for admission hour.
Block 19 Not required.

Block 20 Not required.
Block 21 Not required.
Block 22 Type or print patient's two-digit status code on the last day of the billing period.
Block 23 Not required.
Block 24 Not required.
Block 25 Not required.
Block 26 Not required.
Block 27 Not required.
Block 28 Not required.
Block 29 Not required.
Block 30 Not required.
Block 31 Blank field.
Block 32 Not required.
Block 33 Not required.
Block 34 Not required.
Block 35 Not required.
Block 36 Not required.
Block 37 Blank field.
Block 38 Not required.
Block 39 Not required.
Block 40 Not required.
Block 41 Not required.
Block 42 Type or print Revenue Center Code(s).
Block 43 Type or print Revenue Center Code description(s).
Block 44 Type or print applicable private/semi-private room rate, and the CPT or HCPCS codes and modifiers based on bill type (inpatient or outpatient).
Block 45 Not required.
Block 46 Type or print units of service for inpatient. For outpatient, enter units of service for each RCC.
Block 47 Type or print total charges by RCC and procedure code.
Block 48 Not required.
Block 49 Blank field.
Block 50 Type or print program payer: U.S. DOL-OWCP-FECA, -BLBA or -EEOICPA, as appropriate, and Medicare number (on B) for inpatient services.
Block 51 Type or print Provider I.D. Number provided by the program being billed, and Medicare number for inpatient services.
Block 52 Not required.
Block 53 Not required.
Block 54 Type or print the amount of any prior payments made.
Block 55 Not required.
Block 56 Not required.
Block 57 Blank field.
Block 58 Type or print insured's last name, first name.
Block 59 Not required.
Block 60 For EEOICPA: type or print patient's SSN. For FECA and BLBA: type or print patient's claim number.
Block 61 Not required.
Block 62 Not required.
Block 63 Not required.
Block 64 Not required.
Block 65 Not required.
Block 66 Not required.
Block 67 Type or print complete ICD-9-CM diagnosis code for principal diagnosis. Enter the 4th and 5th digits if applicable. Each diagnosis must be valid for the date of service.
Block 68 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 69 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 70 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 71 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 72 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 73 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 74 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 75 Type or print complete ICD-9-CM diagnosis code for other diagnosis (if applicable).
Block 76 Type or print complete ICD-9-CM diagnosis code for admission diagnosis. Enter the 4th and 5th digits if applicable. Each diagnosis must be valid for the date of service.
Block 77 Not required.
Block 78 Blank field.
Block 79 Type or print indicator for type of code used in Blocks 80 and 81.
Block 80 Type or print principal procedure using ICD-9-CM and date of occurrence (MM/DD/YY) during hospitalization. Inpatient claims and all surgical procedures require ICD-9-CM codes. Outpatient claims require CPT/HCPCS codes.
Block 81 Type or print any other procedure using ICD-9-CM and date of occurrence (MM/DD/YY) during hospitalization. Inpatient claims and all surgical procedures require ICD-9-CM codes. Outpatient claims require CPT/HCPCS codes.
Block 82 Not required.
Block 83 Not required.
Block 84 Not required.
Block 85 Signature block for provider representative. Attests to conformance with certifications on the form.
Block 86 Type or print date bill is submitted (MM/DD/YY).

Public Burden Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1215-0176. We estimate that it will take an average of seven minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures and prior use of this common form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S3522, 200 Constitution Avenue NW, Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0176), Washington, DC 20503. **DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.**

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

☐ Statement of Actual Services **– OR –** ☐ Request for Predetermination / Preauthorization

☐ EPSDT / Title XIX

2. Predetermination / Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number	10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID	50. License Number	51. SSN or TIN

52. Phone Number ( ) –

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) Date

54. Provider ID	55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) –

58. Treating Provider Specialty

General Instructions:

The form is designed so that the Primary Payer's name and address (Item 3) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the left and right margins. The upper-right blank space is provided for insertion of the third-party payer's claim or control number.

a) All data elements are required unless noted to the contrary on the face of the form, or in the Data Element Specific Instructions that follow.
b) When a name and address field is required, the full entity or individual name, address and zip code must be entered (i.e., Items 3, 11, 12, 20 and 48).
c) All dates must include the four-digit year (i.e., Items 6, 13, 21, 24, 36, 37, 41, 44, and 53.
d) If the number of procedures being reported exceeds the number of lines available on one claim form the remaining procedures must be listed on a separate, fully completed claim form. Both claim forms are submitted to the third-party payer.

Data Element Specific Instructions

1. **EPSDT / Title XIX** -- Mark box if patient is covered by state Medicaid's **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment program for persons under age 21.
2. Enter number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.
4-11. Leave blank if no other coverage.
8. The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
15. The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
16. Subscriber's or employer group's Plan or Policy Number. May also be known as the Certificate Number. [Not the subscriber's identification number.]
19-23. Complete only if the patient is **not** the Primary Subscriber. (i.e., "Self" not checked in Item 18)
19. Check "FTS" if patient is a dependent and full-time student; "PTS" if a part-time student. Otherwise, leave blank.
23. Enter if dentist's office assigns a unique number to identify the patient that is **not** the same as the Subscriber Identifier number assigned by the payer (e.g., Chart #).
25. Designate tooth number or letter when procedure code directly involves a tooth. Use area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'.
26. Enter applicable ANSI ASC X12 code list qualifier: Use "**JP**" when designating teeth using the ADA's Universal/National Tooth Designation System. Use "**JO**" when using the ANSI/ADA/ISO Specification No. 3950.
27. Designate tooth number when procedure code reported directly involves a tooth. If a range of teeth is being reported use a hyphen ('-') to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.
28. Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: **B** = Buccal; **D** = Distal; **F** = Facial; **L** = Lingual; **M** = Mesial; and **O** = Occlusal.
29. Use appropriate dental procedure code from current version of *Code on Dental Procedures and Nomenclature*.
31. Dentist's full fee for the dental procedure reported.
32. Used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.
33. Total of all fees listed on the claim form.
34. Report missing teeth on each claim submission.
35. Use "Remarks" space for additional information such as 'reports' for '999' codes or multiple supernumerary teeth.
36. Patient Signature: The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
37. Subscriber Signature: Necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization of payment. It does not create a contractual relationship between the dentist and the payer.
38. ECF is the acronym for **E**xtended **C**are **F**acility (e.g., nursing home).
48-52. Leave blank if dentist or dental entity is **not** submitting claim on behalf of the patient or insured/subscriber.
48. The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.
49. Identifier assigned to Billing Dentist of Dental Entity other than the SSN or TIN. Necessary when assigned by carrier receiving the claim
50. Refers to the license number of the billing dentist. This may differ from that of the treating (rendering) dentist that appears in the treating dentist's signature block.
52. The Internal Revenue Service requires that either the Social Security Number (SSN) or Tax Identification Number (TIN) of the billing dentist or dental entity be supplied **only** if the provider accepts payment directly from the third-party payer.
When the payment is being accepted directly report the: 1) SSN if the billing dentist in unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing entity is a group practice or clinic.
53. The treating, or rendering, dentist's signature and date the claim form was signed. Dentists should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
56. Full address, including city, state and zip code, where treatment performed by treating (rendering) dentist.
58. Enter the code that indicates the type of dental professional rendering the service from the 'Dental Service Providers' section of the *Healthcare Providers Taxonomy* code list. The current list is posted at: http://www.wpc-edi.com/codes/codes.asp. The available taxonomy codes, as of the first printing of this claim form, follow printed in **boldface**.

122300000X Dentist -- A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.

Many dentists are general practitioners who handle a wide variety of dental needs.

1223G0001X General Practice

Other dentists practice in one of nine specialty areas recognized by the American Dental Association:

1223D0001X Dental Public Health
1223E0200X Endodontics
1223P0106X Oral & Maxillofacial Pathology
1223D0008X Oral and Maxillofacial Radiology
1223S0112X Oral & Maxillofacial Surgery
1223X0400X Orthodontics
1223P0221X Pediatric Dentistry (Pedodontics)
1223P0300X Periodontics
1223P0700X Prosthodontics

ATTENDANT'S ALLOWANCE

If an injury is so severe that the employee is unable to care for his or her physical needs, such as feeding, bathing, or dressing, an attendant's allowance of up to $1500 per month may be paid. The assistance required must be personal in nature; an attendant's allowance cannot be paid for housekeeping services. An employee who believes he or she is entitled to such an allowance should contact the district office by letter for instructions on how to apply for this benefit.

Effective January 4, 1999, all attendant's allowances are paid as medical expenses. A home health aide, licensed practical nurse, or similarly trained individual is to provide the necessary services, including assistance in feeding, bathing, and using the toilet. Like other medical providers, the attendant is to bill OWCP periodically using Form HCFA-1500.

HOUSE AND VEHICLE MODIFICATIONS

An employee whose injury severely restricts mobility and independence in the normal functions of living, either permanently or for a prolonged period, may be entitled to house or vehicle modifications. Examples of such conditions include blindness, profound bilateral deafness, and total loss of use of limbs such that a prosthesis, wheelchair, or leg brace is required. An employee may apply for such modifications by narrative letter. They must be recommended by the attending physician and the modified house or vehicle must be consistent with the employee's pre-injury standard of living.