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						
b						
c						
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
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50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
							A
							B
							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
					B
					C

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

84 REMARKS	OTHER PHYS. ID	
a		a
b		B b
c		
d		

85 PROVIDER REPRESENTATIVE X — 86 DATE

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 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 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 FECA, BLACK LUNG AND EEOICPA 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 40742-8300, unless otherwise instructed.
BLBA: Send all forms for BLBA to the Federal Black Lung Program, P.O. Box 8302, London, KY 40742-8302, unless otherwise instructed.
EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 8304, London, KY 40742-8304, 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 For BLBA: If billing for private room, the semi-private room rate is 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 and BLBA: type or print patient's SSN. For FECA: 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.**