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PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

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 TO MM DD YY

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 TO MM DD YY

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)

Instructions for Completing OWCP-1500 Health Insurance Claim 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 compensable illnesses defined under that Act. All services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to give relief, reduce the degree or period of the disability or illness, or aid in lessening the amount of the monthly compensation, may be furnished. "Physician" includes all Doctors of Medicine (M.D.), podiatrists, dentists, clinical psychologists, optometrists, chiropractors, or osteopathic practitioners within the scope of their practice as defined by State law. However, the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

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 relative value scale fee schedule 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); correct CPT code and modifier(s) is required. Incorrect coding will result in inappropriate 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.

REPORTS: A medical report that indicates the dates of treatment, diagnosis(es), findings, and type of treatment offered is required for services provided by a physician (as defined above). For FECA claimants, the initial medical report should explain the relationship of the injury or illness to the employment. Test results and x-ray findings should accompany billings.

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.

SIGNATURE OF PHYSICIAN OR SUPPLIER: Your signature in Item 31 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 Item 31 also indicates that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by you or were furnished incident to your professional services by your employee under your immediate personal supervision, except as otherwise expressly permitted by FECA, Black Lung or EEOICPA 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. 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.

For Black Lung claims, by signing your name in Item 31, you further certify that the services performed were for a Black Lung-related disorder.

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

We are authorized by OWCP to ask you for information needed in the administration of the FECA, Black Lung and EEOICPA programs. Authority to collect information is in 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. 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 CPT codes will delay payment or may result in rejection of the claim 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 systems of records. See 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.

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.

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.

Item 1. Leave blank.
Item 1a. Enter the patient's claim number.
Item 2. Enter the patient's last name, first name, middle initial.
Item 3. Enter the patient's date of birth (MM/DD/YY) and check appropriate box for patient's sex.
Item 4. For FECA: leave blank. For BLBA and EEOICPA: complete only if patient is deceased and this medical cost was paid by a survivor or estate. Enter the name of the party to whom medical payment is due.
Item 5. Enter the patient's address (street address, city, state, ZIP code; telephone number is optional).
Item 6. Leave blank.
Item 7. For FECA: leave blank. For BLBA and EEOICPA: complete if Item 4 was completed. Enter the address of the party to be paid.
Item 8. Leave blank.
Item 9. Leave blank.
Item 10. Leave blank.
Item 11. For FECA: enter patient's claim number. OMISSION WILL RESULT IN DELAYED BILL PROCESSING. For BLBA and EEOICPA: leave blank.

Item 11a. Leave blank.
Item 11b. Leave blank.
Item 11c. Leave blank.
Item 11d. Leave blank.
Item 12. The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by witness and relationship to patient indicated.
Item 13. Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contractual arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, a person with a power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.
Item 14. Leave blank.
Item 15. Leave blank.
Item 16. Leave blank.
Item 17. Leave blank.
Item 18. Leave blank.
Item 19. Leave blank.
Item 20. Leave blank.
Item 21. Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification of Disease, 9th Edition, Clinical Modification or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.
Item 22. Leave blank.
Item 23. Leave blank.
Item 24. Column A: enter month, day and year (MM/DD/YY) for each service/consultation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in Column G.
Column B: enter the correct CMS/OWCP standard "place of service" (POS) code (see below).
Column C: not required.
Column D: enter the proper five-digit CPT (current edition) code and modifier(s), the HCPCS, or the OWCP generic procedure code.
Column E: enter the diagnostic reference number (1, 2, 3 or 4 in Item 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.
Column F: enter the total charge(s) for each listed service(s).
Column G: enter the number of services/units provided for period listed in Column A. Anesthesiologists enter time in total minutes, not units.
Column H: leave blank.
Column I: leave blank.
Column J: leave blank.
Column K: leave blank.
Item 25: Enter the Federal tax I.D.
Item 26: Provider may enter a patient account number that will appear on the remittance voucher.
Item 27: Leave blank.
Item 28: Enter the total charge for the listed services in Column F.
Item 29: If any payment has been made, enter that amount here.
Item 30: Enter the balance now due.
Item 31: For BLBA and EEOICPA: sign and date the form. For FECA: signature stamp or "signature on file" is acceptable.
Item 32: Enter complete name of hospital, facility or physician's office were services were rendered.
Item 33: Enter (1) the name and address to which payment is to be made, and (2) your DOL provider number after "PIN #" if you are an individual provider, or after "GRP #" if you are a group provider. FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE A REJECTION OF THE BILL FOR INCOMPLETE/INACCURATE INFORMATION.

Place of Service (POS) Codes for Item 24B

3	School
4	Homeless Shelter
5	Indian Health Service Free-Standing Facility
6	Indian Health Service Provider-Based Facility
7	Tribal 638 Free-Standing Facility
8	Tribal 638 Provider-Based Facility
11	Office
12	Patient Home
15	Mobile Unit
20	Urgent Care
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center (CMHC)
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

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 1215-0055. 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 (1215-0055), Washington, DC 20503. **DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.**