

[INFORMATIONAL ONLY]

**REQUIRED DATA ELEMENTS FOR ELECTRONIC AND PAPER PHARMACY BILLS**

**GENERAL INFORMATION:** Claims filed under the FECA (5 USC 8101 *et seq.*) are for employment-related illness or injury. Claims filed under the EEOICPA (42 USC 7384 *et seq.*) are for occupational illnesses defined under that Act. Claims filed under the BLBA (30 USC 901 *et seq.*) are for Black Lung Disease as defined under that Act. Benefits provided under all three of these statutes include medicinal drugs prescribed for the treatment of covered injuries or occupational illnesses.

**FEES:** The Department of Labor's Office of Workers' Compensation Programs (OWCP) is the responsible party for payment of bills submitted by pharmacies providing prescribed medicinal drugs to claimants eligible under the FECA, EEOICPA and BLBA. OWCP uses a drug-specific fee schedule based on the average wholesale price plus a dispensing fee when it pays these bills. Schedule limits are applied using an automated billing system based on the identification of drugs using the National Drug Code (NDC) number; thus, use of correct codes is required. Incorrect code usage will result in inappropriate or delayed payment. For specific information about schedule limits, call the OWCP program office with jurisdiction over the claim.

**SIGNATURE OF PROVIDER:** Your signature indicates your agreement to accept the charge determination for medicinal drugs you have dispensed as payment in full, and indicates your agreement not to seek payment from the patient of any amounts not paid as the result of the application of OWCP's fee schedule (appeals are allowed). Your signature also indicates that the drugs listed on your bill were provided, and that the billing information you have submitted is complete and accurate. Finally, your signature indicates your understanding that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

**PAPER BILL SUBMISSION:** Send paper pharmacy bills to the Central Mailroom, P.O. Box 8300, London, KY 40742, unless otherwise instructed.

**REQUIRED DATA ELEMENTS FOR PAPER BILLS:** A brief description of each required data element for paper bills is listed below. For further information contact OWCP.

Data Element	Allowable Values	Comments
Authorized Pharmacy Representative Signature	Valid signature or signature substitute acceptable to OWCP	Y/N Signature indicator
Cardholder Name	Claimant name	For eligibility validation only

<b>Data Element</b>	<b>Allowable Values</b>	<b>Comments</b>
Cardholder's ID Number	FECA claim number, SSN for BLBA and EEOICPA	If number is not on the eligibility file, the bill will be returned with a form letter stating that the bill either lacks a claim number or has an incorrect claim number and requesting the pharmacy to obtain the correct number and resubmit the bill
Days Supply Dispensed		
Group Number		EIN
Metric Quantity		
NDC – package number		
NDC – product name		
NDC – product number		
New/Refill		N/R Indicator
Patient/Authorized Rep Signature	May be signature on file	
Pharmacy Information – City, State, ZIP Code		
Pharmacy Information – Date Prescription(s) filled		
Pharmacy Information – Name		
Pharmacy Information – Pharmacy Number	OWCP provider number	May be changed to the NABP number in the future
Pharmacy Information – Street		
Prescription Number		
Total Price		
Compound Drug Indicator		Y/N Indicator

### **Public Burden Statement**

The authority for requesting the following information is (5 USC 8101, 42 USC 7384 and 30 USC 901). The information will be used to provide payment for pharmaceuticals covered under the Act. Furnishing the requested information is required to obtain or retain benefits. Failure to furnish the requested information will result in the contractor staff not being able to process the bills for payment.

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 1215-0194. The time required to complete this information collection is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed form to this address.