

Claim for Medical Reimbursement

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



Provide all information requested below. **DO NOT FILL IN SHADED AREAS.** Read the attached information in order to ensure the submission of all required documentation. Maintain a copy of all documentation for your records.

OMB No. 1215-0193
 Expires: XX/XX/XXXX

PERSONAL INFORMATION

Name

 Last First M.I.

OWCP File Number

Address

 Street/P.O. Box/Apt No.

 City State Zip Code

Telephone Number

() _____

FOR DOL USE ONLY

PROVIDER INFORMATION

Name of Doctor's Office, Hospital, Pharmacy or Medical Supply Company where expense was incurred. (A separate OWCP-915 must be filed for each provider)

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM, DD, YY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Total Reimbursement
 \$ _____

I certify that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered condition. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain reimbursement from OWCP is subject to civil penalties and/or criminal prosecution.

I authorize any provider named above to release information to the US Department of Labor, OWCP if necessary for the proper adjudication of this claim.

Signature _____ Date _____

INSTRUCTIONS FOR USE OF FORM OWCP-915

- This form is to be used to seek reimbursement for out of pocket medical expenses pertaining to the treatment of an accepted condition. Form OWCP-915 can be used to seek reimbursement for expenses in regard to medical treatment, prescription medication and medical supplies.
- Please submit a separate reimbursement claim for each provider where an out of pocket expense was incurred.
- Please print clearly and legibly. Reference your OWCP file number on all documentation. Maintain a copy of the completed OWCP-915 and supporting documentation for your records.

DOCUMENTATION REQUIRED FOR MEDICAL REIMBURSEMENT

Prescription Medication

1. Completed OWCP-915
2. A paper pharmacy Billing Form, which must be attached to the OWCP-915 and must include the following information:
 - a. Name, address and telephone number of pharmacy
 - b. Pharmacy provider number
 - c. Prescription number
 - d. Name of claimant
 - e. Date of purchase
 - f. Eleven Digit National Drug Code (NDC#)
 - g. New prescription or refill number
 - h. Quantity of medication (e.g. # of pills or ml/cc)
 - i. Amount paid by employee per medication
3. Proof of payment (can include cash receipt, cancelled check or credit card slip)

Medical Expense other than prescription medication

1. Completed OWCP-915
2. Physicians and other health care providers (i.e. physical therapists) must complete Form OWCP-1500. Hospitals and other facilities, such as ambulatory surgical centers, skilled nursing facilities, etc. must submit their bills on Form OWCP-92. Every form must be completed in its entirety in the same manner as bills submitted by the provider directly to OWCP. The amount paid by the claimant must be indicated. The OWCP-1500 or OWCP-92 must be attached to this form. It is the responsibility of the person submitting a claim for reimbursement to obtain a completed OWCP-1500 or OWCP-92 from the provider rendering service. *Without a fully completed OWCP-1500 or OWCP-92, the OWCP is not able to process a reimbursement.*
3. Attach any proof of payment (can include cash receipt, cancelled check or credit card slip)

Travel

Do not use Form OWCP-915 to submit a claim for travel reimbursement. Claims for travel reimbursement should be submitted on Form OWCP-957.

Public Burden Statement

Under 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. Submission of the information requested by this collection is voluntary; however, failure to provide the information will prevent payment of the requested reimbursement. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including 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, RoomS3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim form to this address.

PRIVACY ACT STATEMENT

The Privacy Act of 1974, as amended (5 U.S.C. 552a) authorizes 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, 42 USC 7384d, E.O. 9397 and E.O. 13179. The information we obtain with this form is used to identify you and to determine your eligibility for reimbursement. It is also used to decide if the services and supplies you received are covered by these programs and to ensure 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. 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-6 and DOL/ESA-49 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished.