

HOW TO SUBMIT OWCP - 1500 BILLS TO THE FEDERAL BLACK LUNG PROGRAM

**OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF COAL MINE WORKERS' COMPENSATION**

The services performed by the following providers should be billed on the OWCP -1500 Form:

◦ Physicians (MD, DO)	◦ DME Suppliers	◦ Independent Laboratories
◦ Ambulatory Surgical Centers	◦ Home Nursing Agencies	◦ Ambulance
◦ Pulmonary Rehabilitation	◦ Pharmacies (Optional)	◦ Nursing Homes (Limited)

BILLS SHOULD BE SENT TO:

US Department of Labor
P O Box 8302
London, KY 40742-8302

HOW WE WILL PROCESS YOUR BILL:

Bills will be processed by Affiliated Computer Services (ASC)/ XEROX, the Fiscal Agent for the Office of Worker's Compensation Programs, which includes the Federal Black Lung Program. The ACS/Xerox facility in London, Kentucky will receive and scan your bill. If the bill must be returned without processing, you will be notified with a Return to Provider (RTP) letter giving the reason. The bill should be resubmitted with the necessary corrections to the London, Kentucky address noted above.

After the bill is scanned and entered into the processing system, it will be reviewed to determine if it is payable under the Federal Black Lung Program. You will then be issued a Remittance Voucher (RV), approximately 1 week from date of payment, describing, if applicable, the payment made, a reason for denial, and a reason why full payment was not approved. The RV will be mailed to you from London, Kentucky. At approximately the same time, an electronic funds transfer of the approved amount will be made to your financial institution.

ELECTRONIC SERVICES

ACS is pleased to offer enhanced services on its web portal (<http://owcp.dol.acs-inc.com/portal/main.do>). To take advantage of these services, and others that may be added in the future, you will need to know the patient's information, including the claim number and the Black Lung Benefits Identification Card number, which is a 10-digit number on the reverse side of the card that every eligible beneficiary receives. The claim number is the patient's Social Security number, which does not appear on the card for security reasons.

REMITTANCE VOUCHER RETRIEVAL

Retrieving DOL remittance vouchers via electronic media offers the advantage of speed in retrieval. Providers may access reports online as well as receive paper copies of the remittance vouchers.

The Electronic Data Interchange (EDI) Support Unit assists providers who have questions about electronic bill submission. ACS's EDI Support Unit is available to all providers Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Standard Time at 800-987-6717.

EDI Support will:

- Provide information on available services.
- Assist in enrolling users for report retrieval.
- Provide technical assistance on retrieval difficulties.

CLAIMANT ELIGIBILITY INQUIRY

Because the Federal Black Lung Program is limited to coverage of treatment for the patient's pneumoconiosis and related illnesses, the web portal also allows you to help determine if a procedure or diagnosis is covered, or if the patient was covered on a specific date of service.

USING THE OWCP -1500

Physician services rendered in the treatment of a miner's pulmonary disease are reimbursable under the following categories: office visits, hospital visits, procedures at an outpatient clinic, home visits, pulmonary consultations, immunizations for flu and pneumonia, radiology for the diagnosis and/or treatment of a pulmonary disease, pulmonary therapy, and prescriptions for and administration of drugs on the lists of drugs and laboratory tests covered by the Department of Labor program. When care is rendered for an acute condition causing hospitalization, emergency room, or ambulatory care services, the acute condition must be indicated on the billing form before reimbursement can be considered.

AUTHORIZATION REQUIREMENTS

The Federal Black Lung Program pays for medical services rendered to coal miners disabled from pneumoconiosis (black lung disease). Some services, specifically home nursing services, durable medical equipment, require prior authorization in the form of a Certificate of Medical Necessity (CM-893.) Because the Federal Black Lung Program has unique requirements and standards for authorization, the CM-893 is required. To request a Certificate of Medical Necessity, you may contact the claimant's district office or download and print the CMN at www.dol.gov/owcp/dcmwc/regs/compliance/blforms.htm. See Attachment 1 or go to

<http://www.dol.gov/owcp/dcmwc/blcontac.htm> for the appropriate DCMWC District Office address and telephone number.

Nursing homes that provide services requiring pre-approval must also follow these procedures, and bill using the OWCP -1500. The Federal Black Lung Program does not cover room and board for nursing homes, but will pay for covered physicians' services and prescriptions in addition to pre-approved services.

BILLING REQUIREMENTS

1. **All bills must contain the 9-digit Social Security number of your patient and your 9-digit DCMWC provider number. Your patient's SSN is not shown on the Black Lung Benefits Identification Card for privacy reasons.**
2. Anesthesia services must be billed with the appropriate anesthesia CPT code (00100 – 01999).

The following modifiers must be used for services requiring anesthesia:

Anesthesia	AA
------------	----

3. For surgical procedures, no modifier is necessary. If an assistant surgeon is needed, services must be coded with modifier 80:

Assistant Surgeon	80
-------------------	----

4. Drugs dispensed/administered at the physician's office:

Using procedure codes J3490, J8499, J8999 and J9999 will require a National Drug Code.

5. When billing for services over a period of time, use the "From" and "Through" dates to represent the date range, with the appropriate units for each CPT/HCPCS code billed per the service code description.

The following modifiers must be used for procedures billed as professional or technical components if a full fee is not billed:

Professional	26
Technical	TC

The following modifiers must be used for durable medical equipment billed as purchase or rental:

Purchase	NU
Rental	RR

6. For additional instructions, please refer to Attachment 2, a detailed OWCP -1500 listing with the required fields.

Attachment 1 - Black Lung District Office List

<p><u>JOHNSTOWN, PENNSYLVANIA</u></p>	<p>Virginia</p> <p>Thirty-seven counties in Pennsylvania: Adams, Bedford, Berks, Blair, Bucks, Cambria, Cameron, Centre, Chester, Clearfield, Clinton, Cumberland, Dauphin, Delaware, Elk, Franklin, Fulton, Huntingdon, Indiana, Jefferson, Juniata, Lancaster, Lebanon, Lycoming, McKean, Mifflin, Montgomery, Montour, Northumberland, Perry, Philadelphia, Potter, Somerset, Snyder, Tioga, Union, and York.</p>
<p><u>GREENSBURG, PENNSYLVANIA</u></p>	<p>Maryland</p> <p>Sixteen counties in Pennsylvania: Allegheny, Armstrong, Beaver, Butler, Clarion, Crawford, Erie, Fayette, Forest, Greene, Lawrence, Mercer, Venango, Warren, Washington, and Westmoreland</p> <p>Connecticut, Delaware, District of Columbia, Maine, Massachusetts, New Hampshire, New Jersey, New York, Puerto Rico, Rhode Island, Vermont</p> <p>The following fourteen counties in Pennsylvania: Bradford, Carbon, Columbia, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Wayne, and Wyoming</p>
<p><u>CHARLESTON, WEST VIRGINIA</u></p>	<p>Fifteen counties in West Virginia including Boone, Cabell, Fayette, Kanawha, Lincoln, Logan, McDowell, Mercer, Mingo, Monroe, Putnam, Raleigh, Summers, Wayne and Wyoming.</p>
<p><u>PARKERSBURG, WEST VIRGINIA</u></p>	<p>All counties in West Virginia not under the jurisdiction of the Charleston Office.</p>

Continued on following page

PIKEVILLE, KENTUCKY

**U.S. Department of Labor
ESA/OWCP/DCMWC
164 Main Street, Suite 508
Pikeville, Kentucky 41501
Commercial: (606) 432-0116
Toll-Free: (800) 366-4599**

All claims from Kentucky. This office is part of the Jacksonville Region

MOUNT STERLING, KENTUCKY

**U.S. Department of Labor
ESA/OWCP/DCMWC
402 Campbell Way
Mount Sterling, Kentucky 40353
Commercial: (859) 498-9700
Toll-Free: (800) 366-4628**

Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, and Tennessee. This office is part of the Jacksonville Region.

COLUMBUS, OHIO

**U.S. Department of Labor
ESA/OWCP/DCMWC
1160 Dublin Road Suite 300
Columbus, Ohio 43215
Commercial: (614) 469-5227
Toll-Free: (800) 347-3771**

Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin.

DENVER, COLORADO

**U.S. Department of Labor-Black Lung
ESA/OWCP/DCMWC
1999 Broadway, Suite 690
P.O. Box 46550
Denver, Colorado 80201-6550
Commercial: (720) 264-3100
Toll-Free: (800) 366-4612**

Alaska, American Samoa, Arizona, Arkansas, California, Colorado, Guam, Hawaii, Idaho, Iowa, Kansas, Louisiana, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, the North Mariana Islands, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, and Wyoming.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE

1. <input type="checkbox"/> MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#)							1a. INSURED I.D. NUMBER (For Program in Item 1)				
2. PATIENT'S NAME (Last, First, Middle Initial)			3. PATIENT'S BIRTH DATE		SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. INSURED'S NAME (Last, First, Middle Initial)				
5. PATIENT'S ADDRESS (Street, City, State, Zip)			6. PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			7. INSURED'S ADDRESS (Street, City, State, Zip)					
TELEPHONE (Include Area Code):			8. RESERVED FOR NUCC USE			TELEPHONE (Include Area Code):					
9. OTHER INSURED'S NAME (Last, First, Middle Initial)			10. PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> Yes <input type="checkbox"/> No			a. INSURED'S DATE OF BIRTH					
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> Yes <input type="checkbox"/> No			SEX <input type="checkbox"/> M <input type="checkbox"/> F					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No			b. OTHER CLAIM ID (Designated by NUCC)					
d. PATIENT'S PLAN OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME					
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 ILLNESS, INJURY, or PREGNANCY (LMP) QUAL. ↓			15. OTHER DATE QUAL. ↓		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM: _____ TO: _____						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. _____ 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: _____ TO: _____						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? <input type="checkbox"/> Yes <input type="checkbox"/> No \$ CHARGES _____						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24e) ICD Ind. <input type="checkbox"/>					22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____						
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____					23. PRIOR AUTHORIZATION NUMBER _____						
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER (A-L)	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSOT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER NPI #
From	To										
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
25. FEDERAL TAX I.D. NUMBER		SSN <input type="checkbox"/>	EIN <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> Yes <input type="checkbox"/> No		28. TOTAL CHARGE \$ _____	29. AMOUNT PAID \$ _____	30. Rsvd for NUCC Use	
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. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____				33. BILLING PROVIDER INFO & PH # a. _____ b. _____				

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 act, may be prosecuted under applicable Federal or State laws.

**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. Your response regarding the medical service(s) received or the amount charged is required to receive payment for the claim. See 20 CFR §§ 10.801, 30.701, 725.406, 725.701, and 725.704. 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, 10th 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 letter (A, B, C, etc. 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: Enter NPI. For FECA: required. OMISSION WILL RESULT IN DELAYED BILL PROCESSING.
- 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 where services were rendered. Item 32a. Enter NPI. Item 32b. Enter taxonomy number.
- 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.
- Item 33a. Enter NPI.
- Item 33b. Enter taxonomy number.

Place of Service (POS) Codes for Item 24B

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

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 1240-0044. 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 (1240-0044), Washington, DC 20503. **DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.**

NOTICE

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or your claims examiner to ask about this assistance.

Attachment 2 – Detailed Instructions for Completion of OWCP-1500

OWCP –1500 Claim Item	Title	Action	Required?
1	Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	No Entry Required.	N
1a	Insured's ID Number	Mandatory Field. Enter the claimant's case number.	Y
2	Patient's Name	Enter the claimant's last name, first name, and middle initial.	Y
3	Patient's Birth Date Sex	Enter the claimant's 8-digit birth date (MM DD CCYY). Use an "X" to mark the appropriate box for patient sex.	Y
4	Insured's Name	Enter the claimant's last name, first name, and middle initial.	Y
5	Patient's Address Telephone Number	Enter the claimant's address Enter the claimant's telephone number.	Y
6	Patient's Relationship to claimant	No Entry Required.	N
7	Insured's Address, Telephone Number	No Entry required unless the claimant is covered by other insurance.	N
8	Reserved for NUCC Use	No Entry Required.	N
9a-d	Other Insured's Name	If Item Number 11d is marked, complete fields 9 and 9a-d, otherwise leave blank.	N
9a	Other Insured's Policy or Group Number	Enter the policy or group number of the claimant.	N
9b	Reserved For NUCC Use	No Entry Required	N
9c	Reserved For NUCC Use	No Entry Required	N
9d	Insurance Plan Name or Program Name	Enter the claimant's insurance plan or program name.	N
10a-c	Is Patient's Condition Related to:	When appropriate, enter an X in the correct box.	N
10d	Claim Codes (Designated By NUCC)	No Entry Required.	N
11	Insured's Policy, Group, or FECA Number	Enter the claimant's policy or group number as it appears on the claimant's health care identification card. If Item Number 4 is completed, then this field should be completed.	N

OWCP –1500 Claim Item	Title	Action	Required?
11a	Insured's Date of Birth Sex	Enter the 8-digit date of birth (MM DD CCYY) of the claimant. Enter an X to indicate the sex of the claimant.	N
11b	Insured's Employer's Name or School Name	Enter the name of the claimant's employer or school.	N
11c	Insurance Plan Name or Program Name	Enter the insurance plan or program name of the claimant.	N
11d	Is there another Health Benefit Plan?	When appropriate, enter an X in the correct box. If marked "YES", complete 9 and 9a–d.	N
12	Patient's or Authorized Person's Signature	Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6 digit format (MMDDYY) or 8-digit format (MMDDCCYY). If there is no signature on file, leave blank or enter "No Signature on File."	Y
13	Insured's or Authorized Person's Signature	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."	Y
14	Date of current illness, injury or pregnancy	No Entry Required.	N
15	Other Date, Qualifier	No Entry Required.	N
16	Dates Patient Unable to Work in Current Occupation	No Entry Required.	N
17	Name of Referring Provider or Other Source	Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered, or supervised the service(s) or supply(s) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider	N
17 a	Other ID#	The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.	N
17 b	NPI #	Enter the NPI number of the referring, ordering, or supervising provider.	N
18	Hospitalization Dates Related to Current Services	No Entry Required.	N
19	Additional Claim	No Entry Required.	N

OWCP –1500 Claim Item	Title	Action	Required?
	Information(Designated by NUCC)		
20	Outside Lab? \$Charges	Complete this field when billing for purchased services.	N
21	Diagnosis or Nature of Illness or Injury ICD Ind	Enter the diagnosis/condition. List up to 12 ICD-10-CM diagnosis codes. Enter '9' if using ICD9 codes. Enter '0' if using ICD10 codes.	Y
22	Resubmission Code, Original Ref No	No Entry Required.	N
23	Prior Authorization Number	Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service. (Optional)	N
24a	Date(s) of Service	Mandatory Field. Enter the beginning date of service in month, day, year format. Services rendered in one calendar month may be billed on one line with a "From Date" and a "To Date."	Y
24b	Place of Service	Mandatory Field. Enter the two-digit place of service (POS) code for each procedure performed.	Y
24c	EMG	No Entry Required.	N
24d	Procedures, Services, or Supplies	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service.	Y
24e	Diagnosis Pointer	Enter the diagnosis code pointer reference letter as shown in Item Number 21 (A,B,C, etc.) to relate the date of service and the procedures performed to the primary diagnosis.	Y
24f	\$ Charges	Enter number right justified in the dollar area of the field. Do not use commas. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.	Y
24g	Days or Units	Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.	Y
24h	EPSDT/Family Plan	No Entry Required.	N

OWCP –1500 Claim Item	Title	Action	Required?
24i	ID Qualifier	Enter in the shaded area of 24i the qualifier identifying if the number is a non-NPI.	N
24j	Rendering Provider ID #	Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the un-shaded area of the field.	Y
25	Federal Tax ID Number	Enter the provider of service or supplier federal tax ID (employer identification number) or Social Security number. Enter an X in the appropriate box to indicate which number is being reported.	Y
26	Patient's Account No.	Enter the patient's account number assigned by the provider of services or supplier's accounting system.	N
27	Accept Assignment	No Entry Required.	N
28	Total Charge	Enter total charges for the services (i.e., total of all charges in 24f).	Y
29	Amount Paid	Enter total amount the patient or other payers paid on the covered services only. Enter number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.	N
30	Rsvd For NUCC Use	No Entry Required.	N
31	Signature of Physician or Supplier Including Degrees or Credentials Bill Date	Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit or 8 digit date, or alphanumeric date (e.g., January 1, 2003) that the form was signed.	Y
32	Service Facility Location Information	Enter the name, address, city, state, and zip code of the location where the services were rendered.	Y
32 a	NPI#	Enter the NPI number of the service facility location in 32a.	N
32 b	Other ID#	Enter the two digit qualifier identifying the non-NPI number followed by the ID number.	N
33	Billing Provider Info & Ph #	Enter the provider's or supplier's billing name, address, zip code, and phone number.	Y
33 a	NPI#	Enter the NPI number of the billing provider.	N

OWCP –1500 Claim Item	Title	Action	Required?
33 b	Other ID#	ACS Provider Number is required <i>You may also use a two digit qualifier identifying the non-NPI number followed by the ID number.</i>	Y

Attachment 3 – Place of Service Codes

Place of Service Codes (POS)

Code	Description
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
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
60	Mass Immunization Center
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service