HOW TO SUBMIT OWCP - 1500 BILLS TO ACS

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

◦**Physicians** (MD, DO)	◦**Radiologists**	◦**Independent Laboratories**
◦**Audiologists/Speech Pathologist**	◦**Hearing Aid Specialists**	◦**Therapists**
◦**Community Health Departments**	◦**DME**	◦**Visual Services**
◦**Chiropractors**	◦**Home Health**	◦**Prosthetics/Orthotics**
◦**Ambulatory Surgical Centers**	◦**Home Attendant Services**	◦**Rural Health Clinics**
◦**Ambulance**	◦**Psychologist**	◦**Podiatrist**

As a provider you have the option of sending your bills either electronically or by paper.

PAPER BILLS SHOULD BE SENT TO:

US Department of Labor
P O Box 8300
DFEC Central Mailroom
London, KY 40742-8300

ELECTRONIC BILL SUBMISSION

Submitting DOL bills via electronic media offers the advantage of speed in processing. Providers may submit electronic bills or choose a billing agent that offers electronic bill submission services. Billing agents must enroll as DOL providers.

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 electronic bill submission and report retrieval.
- Process test transmissions.
- Provide technical assistance on transmission difficulties.

AUTHORIZATION REQUIREMENTS

The FECA Program pays for medical services rendered for work-related injury or disease. Some services require prior authorization. Listed below are some of the services that require prior authorization:

◦**All inpatient admissions**	◦**All surgical procedures**
◦**Some Injections**	◦**Home health services**
◦**Some durable medical equipment**	◦**Anesthesia CPT codes 01996**
◦**Physical/Occupational therapy services – Physical/Occupational therapy authorization requests must be accompanied by a physician's prescription and a treatment plan. Authorization will be given for the number of modalities to be done per day and the number of days requested.**	

Routine services such as office/clinic visits, diagnostic tests, and laboratory services do <u>NOT</u> require prior authorization.

Please call (866) 335-5335, fax (800) 215-4901 using the attached authorization forms, or access our website to request an authorization.

BILLING REQUIREMENTS

1. **<u>All bills must contain the Federal Employees' Compensation (FECA) 9-digit case number of your patient or client, as well as, the 9 digit ACS Provider Number.</u>**
2. Anesthesia services must be billed with the appropriate anesthesia CPT code (00100 – 01999).
3. Drugs dispensed at the physician's office, other than injections, require NDC along with the quantity and strength.
4. Facility charges for ambulatory surgical center/outpatient surgery billing must be billed using the surgical CPT code. Please use the SG modifier in addition to the surgical CPT code.
5. When billing for services over a period of time, use the "From" and "Through" dates with the appropriate units for each CPT code billed.
6. Please refer to the attached OWCP -1500 list and the required fields for additional instructions.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE

PATIENT AND INSURED INFORMATION

1. ☐ MEDICARE (Medicare#) ☐ MEDICAID (Medicaid#) ☐ TRICARE (ID#/DoD#) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (ID#) ☐ FECA BLK LUNG (ID#) ☐ 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 ☐ M ☐ F

4. INSURED'S NAME (Last, First, Middle Initial)

5. PATIENT'S ADDRESS (Street, City, State, Zip)

6. PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other

7. INSURED'S ADDRESS (Street, City, State, Zip)

8. RESERVED FOR NUCC USE

TELEPHONE (Include Area Code):

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) ☐ Yes ☐ No

a. INSURED'S DATE OF BIRTH SEX ☐ M ☐ F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) ☐ Yes ☐ No

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ Yes ☐ No

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. PATIENT'S PLAN OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ Yes ☐ No *If yes*, complete items 9, 9a, and 9d.

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? ☐ Yes ☐ No $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24e) ICD Ind. ☐

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From	To	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSCS	MODIFIER	E. DIAGNOSIS POINTER (A-L)	F. $ CHARGES	G. DAYS OR UNITS	H. EPSOT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER NPI #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

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. 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 were 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	Birthing 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.

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.	Y
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 Information(Designated by NUCC)**	No Entry Required.	N
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 reference number (pointer) as shown in Item Number 21 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
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.	~~N~~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.	Y
30	**Rsvd for NUCC Use**	No Entry Required	Y
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.	Y
32 b	**Other ID#**	Enter the two digit qualifier identifying the non-NPI number followed by the ID number.	Y
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.	Y

33 b	**Other ID#**	**ACS Provider Number is required** *You may also use a two digit qualifier identifying the non-NPI number followed by the ID number.*	Y

Place of Service Codes (POS)

Code		Description
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
09		Prison/Correctional Facility
11		Office
12		Patient Home
13		Assisted Living Facility
14		Group Home
15		Mobile Unit
16		Temporary Lodging
17		Walk-in Retail Healh Clinic
18		Place of Employment – Worksite
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
49		Independent Clinic
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
57		Non-residential Substance Abuse Treatment Facility
60		Mass Immunization Center
61		Comprehensive Inpatient Rehabilitation Facility

62		**Comprehensive Outpatient Rehabilitation Facility**
65		**End Stage Rental Disease Treatment Facility**
71		**Public Health Clinic**
72		**Rural Health Clinic**
81		**Independent Laboratory**
99		**Other Place of Service**

Transportation and Travel
Authorization Request
Please fax with supporting medical documentation
800-215-4901

Date Requested _____ Requested by _____

Case file # _____

Claimant Name _____

Claimant Date of Birth _____

Provider Name _____

ACS Provider Number _____

Provider Tax ID _____

Procedure Code Information:

Travel services for codes A0100, A0110, A0120, A0130, A0140, and A0170 are authorized based on private transportation total charges. Travel services for claimant mileage reimbursement A0080 and A0090 are authorized based on total round trip miles.

	Travel Date From	Travel Date To	Code for travel	Description of Travel Service	Estimated Total Charge	Estimated Miles (for claimant travel only)
1:			A0100	Taxi		*N/A*
2:			A0110	Bus, intra- or interstate carrier		*N/A*
3:			A0120	Mini-Bus, mountain area transports, and other transports		*N/A*
4:			A0130	Wheelchair Van		*N/A*
5:			A0140	Air Travel		*N/A*
6:			A0170	Transport Parking Fees/Tolls		N/A
7:			A0080	Mileage	*N/A*	
8:			A0090	Mileage	*N/A*	

Travel from: ☐Hospital ☐Office/Clinic ☐Lab ☐Home
Travel to: ☐Hospital ☐Office/Clinic ☐Lab ☐Home

Comments _____

_____

Please remember to send any supporting medical documentation with request.
Please put Case File # on every page faxed.
800-215-4901

Physical Therapy/Occupational Therapy
Authorization Request
Please fax with supporting medical documentation. Fax # 1-800-215-4901

All Prior Authorization requests must either be faxed on this template or be submitted through the Web Bill Processing Portal (owcp.dol.acs-inc.com). All fields are required and must be complete. Incomplete requests and requests that are not properly coded with CPT or HCPCS cannot be processed and will be returned.

Date Requested _____ Requested by _____ Phone_____

Case file # _____ Claimant's Name_____

Claimant Date of Birth _____ Date of injury _____

Provider Name _____

ACS Provider Number _____ Provider Tax ID _____

Are you in the process of enrolling? ☐ Yes ☐ No

Procedure Code Information: Enter up to Ten Procedure (CPT/HCPCS) codes. For additional procedures, please complete an additional request.

	Date(s) of Service		Procedure CPT/HCPCS		# of Units per code	Frequency	Duration	Total # of Units Requested
	From	To	Code	Modifier				
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Treatment Plan Information :

Body part to be treated	Side of body	ICD-9 code

* Is the requested therapy related to post-operative treatment ? ☐ yes ☐ no

Treatment Frequency Calculation

* To calculate Total Units/Days Requested, use the following formula for each procedure code requested:
# of Units Requested per procedure code x Frequency Requested x Duration Requested

Comments: _____

Please remember to send prescription from attending physician and treatment plan with requests for physical or occupational therapy. Please put Case File # on every page faxed. **Fax #800-215-4901**

General Medical and Surgical
Authorization Request
Please fax with supporting medical documentation
Fax # 1-800-215-4901

All Prior Authorization requests must either be faxed on this template or be submitted through the Web Bill Processing Portal (owcp.dol.acs-inc.com). **All fields are required and must be complete. Incomplete requests and requests that are not properly coded with CPT or HCPCS cannot be processed and will be returned.**

Date Requested _____ Requested by _____Phone _____

Case file # _____ Claimant's Name_____

Claimant Date of Birth _____

Provider Name _____

ACS Provider Number _____ Provider Tax ID _____

Are you in the process of enrolling? ☐ Yes ☐ No

Procedure Code Information: * Up to Five Procedure (CPT/HCPCS/RCC) codes may be entered

Note: For Units/Days Requested in the table below, please enter the number of visits anticipated for each procedure code. (For additional procedures, please complete an additional request)

	Date of Service		**Procedure CPT/HCPC/RCC**		**Unit/Days Requested**
	From Date	To Date	Code	Modifier	Units or Days
1:					
2:					
3:					
4:					
5:					

Treatment Plan Information:

- Specific body part to be treated _____
- Right___, Left_____, Bilateral___, N/A_____
- ICD-9 Diagnosis Code(s) _____
- For Home health requests, frequency_____ duration_____
- Is this a second surgery on the same body part? _____
- Comments: _____

Please put Case File # on every page faxed. **Fax #800-215-4901**

Durable Medical Equipment
Authorization Request
Please fax with supporting medical documentation
Fax# 1-800-215-4901

All Prior Authorization requests must either be faxed on this template or be submitted through the Web Bill Processing Portal (owcp.dol.acs-inc.com). **All fields are required and must be complete. Incomplete requests and requests that are not properly coded with CPT or HCPCS cannot be processed and will be returned.**

Date Requested _____ Requested by _____ Phone _____

Case file# _____ Claimant Name _____

Claimant Date of Birth _____ Claimant Date of Injury _____

Provider Name _____

ACS Provider Number _____ Provider Tax ID _____

Are you in the process of enrolling? Yes No

Procedure Code Information: *Up to Five Procedure (CPT/HCPCS) codes may be entered.
(For additional procedures, please complete an additional template)

	Date of Service		**Procedure**	**Rental (RR) or Purchase (NU) Modifier**	****Units/Days Requested****	**Total Requested Price Per Item**
	From Date	To Date	Code	RR or NU	Units or Days	
1:						
2:						
3:						
4:						
5:						

Treatment Plan Information:

- Specific body part(s) to be treated _____
- Right _____, Left _____, Bilateral _____, N/A _____
- ICD-9 Diagnosis Code (s) _____
- Duration Requested, if rental _____

Is this an implant (Y/N) _____ Total Cost of Implant _____ Total Units Requested _____
****Please add units/days to each item per line****

Comments: _____

Please remember to send prescription from attending physician and treatment plan with requests for DME. Please put Case File # on every page faxed. **Fax# 800-215-4901**