

# HOW TO SUBMIT OWCP-1500 BILLS TO XEROX

## OFFICE OF WORKERS' COMPENSATION PROGRAMS DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION

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

|                                  |                          |                           |
|----------------------------------|--------------------------|---------------------------|
| °Physicians (MD, DO)             | °X-Ray                   | °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               |

### **BILLS SHOULD BE SENT TO:**

US Department of Labor  
P O Box 8304  
London, KY 40742-8304

### **ELECTRONIC REMITTANCE VOUCHER RETRIEVAL**

Retrieving DOL remittance vouchers via electronic media offers the advantage of speed in retrieval. All providers, including pharmacies, 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.

## AUTHORIZATION REQUIREMENTS

The DEEOIC program pays for medical services rendered for employees of the Department of Energy with radiation-related cancer and other illnesses related to radiation, Chronic Beryllium Disease, and Chronic Silicosis. Some services require prior authorization. Listed below are some of the services that require prior authorization:

|                                |   |
|--------------------------------|---|
| °Psychiatric Treatment         | °Acupuncture Treatments                 |
| °Chiropractic Services         | °Home Health Services                   |
| °Durable Medical Equipment     | °Organ Transplant (Including Stem Cell) |
| °Experimental Treatment        | °Clinical Research                      |
| °Hospice Care                  | °Extended Care Facilities               |
| °Vehicle/Housing Modifications | °Massage Therapy                        |

**Routine services such as office/clinic visits, plain x-ray films and laboratory services do NOT require prior authorization.**

Please call (866) 272-2682 or fax (800) 882-6147 to request an authorization.

**To request an authorization via fax, use the appropriate template provided in this packet.**

## BILLING REQUIREMENTS

1. **All bills must contain the Division of Energy Employees Occupational Illness Compensation Program (DEEOIC) 9 digit case identification number of your patient or client and your 9-digit DEEOIC provider number.**
2. All professional services will be paid using the Fee Schedule established by OWCP. This Fee Schedule can be downloaded from <http://www.dol.gov/owcp/regs/feeschedule/fee.htm>.
3. Anesthesia services must be billed with the appropriate anesthesia CPT code (00100 – 01999).
4. Drugs dispensed at the physician's office, other than injections, require NDC.

5. 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.
6. When billing for services over a period of time, use the “From” and “Through” dates with the appropriate units for each CPT code billed.
7. 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

|   |  |                           |   |   |  |   |               |  |                      |                       |                             |
|---|--|---------------------------|---|---|--|---|---------------|--|----------------------|-----------------------|-----------------------------|
| 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<br><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)<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  | a. INSURED'S DATE OF BIRTH _____ SEX <input type="checkbox"/> M <input type="checkbox"/> F  |               |  |                      |                       |                             |
| b. RESERVED FOR NUCC USE  |  |                           | b. AUTO ACCIDENT? _____ PLACE (State) _____<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  | b. OTHER CLAIM ID (Designated by NUCC)  |               |  |                      |                       |                             |
| c. RESERVED FOR NUCC USE  |  |                           | c. OTHER ACCIDENT?<br><input type="checkbox"/> Yes <input type="checkbox"/> 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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, complete items 9, 9a, and 9d.</i> |               |  |                      |                       |                             |
| <b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b><br>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. |  |                           |   |   |  |   |               | 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 _____ DATE _____   |  |                           |   |   |  |   |               | SIGNED _____   |                      |                       |                             |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) _____<br>QUAL: _____  |  |                           |   | 15. OTHER DATE _____<br>QUAL: _____   |  |   |               | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM: _____ TO: _____  |                      |                       |                             |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  |  |                           |   | 17a. _____<br>17b. NPI _____  |  |   |               | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>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. _____<br>E. _____ F. _____ G. _____ H. _____<br>I. _____ J. _____ K. _____ L. _____   |  |                           |   |   |  |   |               | 23. PRIOR AUTHORIZATION NUMBER _____   |                      |                       |                             |
| 24. A. DATE(S) OF SERVICE<br>From _____ To _____  |  | B. PLACE OF SERVICE       | C. EMG  | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)<br>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 # |
|   |  |                           |   |   |  |   |               |  |                      | NPI _____             |                             |
|   |  |                           |   |   |  |   |               |  |                      | NPI _____             |                             |
|   |  |                           |   |   |  |   |               |  |                      | NPI _____             |                             |
|   |  |                           |   |   |  |   |               |  |                      | NPI _____             |                             |
|   |  |                           |   |   |  |   |               |  |                      | NPI _____             |                             |
|   |  |                           |   |   |  |   |               |  |                      | NPI _____             |                             |
|   |  |                           |   |   |  |   |               |  |                      | NPI _____             |                             |
| 25. FEDERAL TAX I.D. NUMBER<br>SSN <input type="checkbox"/> EIN <input type="checkbox"/>  |  | 26. PATIENT'S ACCOUNT NO. |   | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)<br><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.)<br>SIGNED _____ DATE _____   |  |                           |   | 32. SERVICE FACILITY LOCATION INFORMATION<br>a. _____ b. _____  |  |   |               | 33. BILLING PROVIDER INFO & PH #<br>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.

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



| <b>CMS –1500<br/>Claim Item</b> | <b>Title</b>  | <b>Action</b>   | <b>Required?</b> |
|---------------------------------|---|---|------------------|
| 10d                             | <b>Claim Codes (Designated By NUCC)</b>                   | No Entry Required.  | N                |
| 11                              | <b>Insured's Policy, Group, or FECA Number</b>            | 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                |
| 11a                             | <b>Insured's Date of Birth</b><br><b>Sex</b>              | Enter the 8-digit date of birth (MM   DD   CCYY) of the claimant.<br>Enter an X to indicate the sex of the claimant.  | N                |
| 11b                             | <b>Insured's Employer's Name or School Name</b>           | Enter the name of the claimant's employer or school.  | N                |
| 11c                             | <b>Insurance Plan Name or Program Name</b>                | Enter the insurance plan or program name of the claimant.   | N                |
| 11d                             | <b>Is there another Health Benefit Plan?</b>              | When appropriate, enter an X in the correct box. If marked "YES", complete 9 and 9a–d.  | N                |
| 12                              | <b>Patient's or Authorized Person's Signature</b>         | 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                              | <b>Insured's or Authorized Person's Signature</b>         | 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                              | <b>Date of current illness, injury or pregnancy</b>       | No Entry Required.  | N                |
| 15                              | <b>Other Date, Qualifier</b>                              | No Entry Required.  | N                |
| 16                              | <b>Dates Patient Unable to Work in Current Occupation</b> | No Entry Required.  | N                |

| CMS –1500 Claim Item | Title   | Action  | Required? |
|----------------------|---|---|-----------|
| 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<br>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                                  | <b>Mandatory Field.</b> Enter the beginning date of service in month, day, year format.<br><br>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                                    | <b>Mandatory Field.</b> Enter the two-digit place of service (POS) code for each procedure performed.   | Y         |
| 24c                  | EMG   | No Entry Required.  | N         |

| <b>CMS –1500<br/>Claim Item</b> | <b>Title</b>                             | <b>Action</b>   | <b>Required?</b> |
|---------------------------------|--|---|------------------|
| <b>24d</b>                      | <b>Procedures, Services, or Supplies</b> | 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                |
| <b>24e</b>                      | <b>Diagnosis Pointer</b>                 | 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                |
| <b>24f</b>                      | <b>\$ Charges</b>                        | 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                |
| <b>24g</b>                      | <b>Days or Units</b>                     | 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                |
| <b>24h</b>                      | <b>EPSDT/Family Plan</b>                 | No Entry Required.  | N                |
| <b>24i</b>                      | <b>ID Qualifier</b>                      | Enter in the shaded area of 24i the qualifier identifying if the number is a non-NPI.   | N                |
| <b>24j</b>                      | <b>Rendering Provider ID #</b>           | Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.  | N                |
| <b>25</b>                       | <b>Federal Tax ID Number</b>             | 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                |
| <b>26</b>                       | <b>Patient's Account No.</b>             | Enter the patient's account number assigned by the provider of services or supplier's accounting system.  | N                |
| <b>27</b>                       | <b>Accept Assignment</b>                 | No Entry Required.  | N                |
| <b>28</b>                       | <b>Total Charge</b>                      | Enter total charges for the services (i.e., total of all charges in 24f).   | Y                |

| <b>CMS –1500<br/>Claim Item</b> | <b>Title</b>   | <b>Action</b>   | <b>Required?</b> |
|---------------------------------|--|---|------------------|
| <b>29</b>                       | <b>Amount Paid</b>   | 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                |
| <b>30</b>                       | <b>Rsvd For NUCC Use</b>   | No Entry Required   | N                |
| <b>31</b>                       | <b>Signature of Physician or Supplier Including Degrees or Credentials</b><br><br><b>Bill Date</b> | 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                |
| <b>32</b>                       | <b>Service Facility Location Information</b>   | Enter the name, address, city, state, and zip code of the location where the services were rendered.  | Y                |
| <b>32 a</b>                     | <b>NPI#</b>  | Enter the NPI number of the service facility location in 32a.   | N                |
| <b>32 b</b>                     | <b>Other ID#</b>   | Enter the two digit qualifier identifying the non-NPI number followed by the ID number.   | N                |
| <b>33</b>                       | <b>Billing Provider Info &amp; Ph #</b>  | Enter the provider's or supplier's billing name, address, zip code, and phone number.   | Y                |
| <b>33 a</b>                     | <b>NPI#</b>  | Enter the NPI number of the billing provider.   | N                |
| <b>33 b</b>                     | <b>Other ID#</b>   | <b>ACS Provider Number is required</b><br><i>You may also use a two digit qualifier identifying the non-NPI number followed by the ID number.</i>   | Y                |

**Place of Service Codes (POS)**

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

**Authorization Request Form**  
**Please fax with supporting medical documentation**  
**800-882-6147**

Effective January 3, 2005, all Prior Authorization requests must either be faxed on this template or be submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal(<http://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 \_\_\_\_\_

Case file # \_\_\_\_\_

Claimant Name \_\_\_\_\_

Claimant Date of Birth \_\_\_\_\_

Provider Name \_\_\_\_\_

ACS Provider Number \_\_\_\_\_

Provider Tax ID \_\_\_\_\_

Date(s) of Service Requested \_\_\_\_\_

ICD-9/ICD-10 Diagnosis code \_\_\_\_\_

Procedure Code(s) and/or Modifier(s) (CPT, HCPCS, RCC) \_\_\_\_\_

Specific body part to be treated \_\_\_\_\_

Right\_\_\_\_ , Left\_\_\_\_ , Bilateral\_\_\_\_ , N/A\_\_\_\_\_

Units/Days Requested \_\_\_\_\_

Is this a second surgery on the same body part? \_\_\_\_\_

Comments \_\_\_\_\_

**Please remember to send any supporting medical documentation with request.**  
**Please put Case File # on every page faxed.**  
**800-882-6147**



**TRANSPLANT  
PRIOR AUTHORIZATION REQUEST FORM**

Please Fax with Supporting Medical Documentation to:  
800-882-6147

Requests for prior authorization of transplants must be accompanied by clinical documentation that supports the need for the type of transplant being requested.

REQUIRED DOCUMENTATION:

- LETTER OF MEDICAL NECESSITY FROM THE TREATING PHYSICIAN DESCRIBING THE NEED FOR THE TRANSPLANT BEING REQUESTED.
- INITIAL AND RECENT CLINICAL EVALUATION (I.E., DIAGNOSTIC STUDIES AND LABORATORY TEST)
- A COPY OF THE TREATMENT PROTOCOL

**Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.**

DATE of REQUEST: \_\_\_\_\_ CLAIMANT FILE NUMBER \_\_\_\_\_

CLAIMANT NAME: \_\_\_\_\_ CLAIMANT DATE OF BIRTH: \_\_\_\_\_

CLAIMANT PHONE: \_\_\_\_\_

NAME OF AUTHORIZED REPRESENTATIVE: \_\_\_\_\_

AUTHORIZED REPRESENTATIVE PHONE: \_\_\_\_\_

TRANSPLANT SURGEON NAME: \_\_\_\_\_

TRANSPLANT SURGEON ACS PROVIDER NUMBER: \_\_\_\_\_ TRANSPLANT SURGEON TAX ID: \_\_\_\_\_

REFERRING PHYSICIAN NAME: \_\_\_\_\_

REFERRING PHYSICIAN ADDRESS: \_\_\_\_\_

PRIMARY DIAGNOSIS DESCRIPTION: \_\_\_\_\_ ICD-9/ICD-10 CODES: \_\_\_\_\_

\_\_\_\_\_

TYPE OF TRANSPLANT: \_\_\_\_\_ PROCEDURE CODE: \_\_\_\_\_

EXPECTED PROCEDURE DATE: \_\_\_\_\_

NAME OF TRANSPLANT FACILITY: \_\_\_\_\_

TRANSPLANT FACILITY ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME OF TRANSPLANT COORDINATOR: \_\_\_\_\_

TRANSPLANT COORDINATOR PHONE: \_\_\_\_\_



**DEEOIC Home Health  
Authorization Request**

**Please ensure the prescription signed by the physician and the Case/Subscriber Number is included with this authorization request. Please submit fax to 1-800-882-6147.**

Date Requested \_\_\_\_\_ Requested by \_\_\_\_\_

Case/Subscriber Number \_\_\_\_\_

Claimant Name \_\_\_\_\_

Claimant Date of Birth (optional) \_\_\_\_\_

Provider Name \_\_\_\_\_

ACS Provider Number \_\_\_\_\_

Provider Tax ID \_\_\_\_\_

Date(s) of Service Requested \_\_\_\_\_

ICD-9-CM \_\_\_\_\_

Procedure Code(s) and/or Modifier(s) (CPT, HCPCS, RCC):

- T1001    frequency \_\_\_\_\_ duration \_\_\_\_\_ total units \_\_\_\_\_
- T1017    frequency \_\_\_\_\_ duration \_\_\_\_\_ total units \_\_\_\_\_
- T1019    frequency \_\_\_\_\_ duration \_\_\_\_\_ total units \_\_\_\_\_
- T1020    frequency \_\_\_\_\_ duration \_\_\_\_\_ total units \_\_\_\_\_
- T1030    frequency \_\_\_\_\_ duration \_\_\_\_\_ total units \_\_\_\_\_
- T1031    frequency \_\_\_\_\_ duration \_\_\_\_\_ total units \_\_\_\_\_
- S5126    frequency \_\_\_\_\_ duration \_\_\_\_\_ total units \_\_\_\_\_
- S9122    frequency \_\_\_\_\_ duration \_\_\_\_\_ total units \_\_\_\_\_
- S9123    frequency \_\_\_\_\_ duration \_\_\_\_\_ total units \_\_\_\_\_
- S9124    frequency \_\_\_\_\_ duration \_\_\_\_\_ total units \_\_\_\_\_
- S9126    frequency \_\_\_\_\_ duration \_\_\_\_\_ total units \_\_\_\_\_

Comments \_\_\_\_\_

**All supporting documentation must be faxed to 1-800-882-6147. Please ensure the Case/Subscriber Number is included on every faxed page.**

**PT and OT Authorization Request Template**  
**Please Fax with supporting medical documentation**  
**FAX #(800) -882-6147**

Effective January 3, 2005, all Prior Authorization requests must either be faxed on this template or be submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal (<http://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 \_\_\_\_\_

Case file # \_\_\_\_\_ Claimant's Name \_\_\_\_\_

Claimant Date of Birth \_\_\_\_\_ Claimant's DOI \_\_\_\_\_

Provider Name \_\_\_\_\_

ACS Provider Number \_\_\_\_\_

Provider Tax ID \_\_\_\_\_

Date(s) Diagnosis Code \_\_\_\_\_

ICD-9/ICD-10 Diagnoses Code \_\_\_\_\_

Procedure Code(s) and/or Modifier(s) (CPT, HCPCS) \_\_\_\_\_

Specific body part to be treated \_\_\_\_\_

Right\_\_\_\_, Left\_\_\_\_, Bilateral\_\_\_\_, N/A\_\_\_\_

Frequency and Duration Requested \_\_\_\_\_

Treatment Plan (include long/short term goals) \_\_\_\_\_

Comments:

**Please put Case File # on every page faxed. 800-882-6147**

## Helpful Hints for Billing

- ◆ Always use Modifiers. For example for the CPT-4 code (chest-x-ray) 71010 use either modifier -26 or -TC to denote either the professional code or technical code.
- ◆ Pharmacy Providers may use Point of Sale
- ◆ Use website to view status of bill or authorization for services rendered:  
<http://owcp.dol.acs-inc.com>
- ◆ Outpatient Hospital services can be billed on the UB 04 form with appropriate Revenue Code Center Codes requiring CPT/HCPCs codes.
- ◆ All bills must contain the DEEOIC's 9-digit case number of your patient or client and your 9-digit provider number.
- ◆ Laboratory, x-ray, physical therapy, and clinical tests such as EKGs, etc. must be identified with the correct CPT code.
- ◆ Facility charges for ambulatory surgical center/outpatient surgery billing must be billed using the surgical CPT code. Modifier SG should be used.
- ◆ When billing for inpatient services, your Medicare number must be included.