Claim for Medical Reimbursement

U.S Department of Labor Office of Workers' Compensation Programs



Provide all information requested below. DO NO information in order to ensure the submission of a		OMB	No. 1240-000 <i>1</i>	•		
documentation for your records.		Expires: 06/30/2021				
PERSONAL INFORMATION						
Name			OWCP File Number			
Last First	First M.I.					
Address			Telephone Number			
Street/P.O. Box/Apt No.			FOR DOL USE ONLY			
City	State Zip Code					
PROVIDER INFORMATION Name of Doctor's Office, Hospital, Pharmacy or N	Andinal Supply Co	amaany whore ever	anaa waa ingurrad	L (Δ con-	arata OWCD 01	5 must
be filed for each provider)	nedical Supply Co	лпрапу where ехре	ense was incurred	. (А ѕер		
Description of Charge (Medical appointment, name of prescription drug, description of	Date of Service (MM/DD/YYYY)		Amount Paid by Claimant		Have you included Proof of Payment for each item?	
medical product/ supply)	From	То			YES	NO
I certify that the information above is correct and	that the reimburse	ement requested is	Total Reimburs		for the treatmen	ıt of mv
covered condition. I am aware that any person where the from OWCP is subject to civil penalties and/or crist authorize any provider named above to release	ho knowingly make minal prosecution	es any false statem	nent or misreprese	entation	to obtain reimbu	ursement
adjudication of this claim.	inomiation to the	Department of	Labor, OVVCF II I	icocssal	y ioi tile proper	
Signature Date						

INSTRUCTIONS FOR USE OF FORM OWCP-915

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

DOCUMENTATION REQUIRED FOR MEDICAL REIMBURSEMENT

Prescription Medication

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

Medical Expense other than prescription medication

- 1. Completed OWCP-915
- 2. Physicians and other health care providers (i.e. physical therapists) must complete Form OWCP-1500. Hospitals and other facilities, such as ambulatory surgical centers, skilled nursing facilities, etc. must submit their bills on Form OWCP-04. Every form must be completed in its entirety in the same manner as bills submitted by the provider directly to OWCP. The amount paid by the claimant must be indicated. The OWCP-1500 or OWCP-04 must be attached to this form. It is the responsibility of the person submitting a claim for reimbursement to obtain a completed OWCP-1500 or OWCP-04 from the provider rendering service. Without a fully completed OWCP-1500 or OWCP-04, the OWCP is not able to process a reimbursement.
- 3. Proof of payment (can include cash receipt, cancelled check or credit card slip)

Travel

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

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain benefit (30 U. S.C. 901). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, 200 Constitution Avenue, N.W., Room S3524, Washington, DC 20210 and reference the OMB Control Number 1240-0007. Note: Please do not return the completed OWCP-915 form to this address.

PRIVACY ACT STATEMENT

The Privacy Act of 1974, as amended (5 U.S.C. 552a) authorizes OWCP to ask you for information needed in the administration of the FECA, Black Lung and EEOICPA programs. Authority to collect information is in 5 USC 8101 et seq., 30 USC 901 et seq., 38 USC 613, 42 USC 7384d, E.O. 9397 and E.O. 13179. The information we obtain with this form is used to identify you and to determine your eligibility for reimbursement. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) received or the amount charged will prevent payment of the claim. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor systems DOL/GOVT-1, DOL/ESA-6 and DOL/ESA-49 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished.

ACCOMMODATION STATEMENT

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.