Claim for Medical Reimbursement

Reset Print

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

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

OMB No. 1240-0007

Expires: 07/31/2027

PERSONAL INFORMATION

Name

Last First M.I.

OWCP File Number

Address

Street/P.O. Box/Apt No.

City State Zip Code

Telephone Number

FOR DOL USE ONLY

PROVIDER INFORMATION

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

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM/DD/YYYY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
			Total Reimbursement		

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

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

Signature _____ Date _____

INSTRUCTIONS FOR USE OF FORM OWCP-915

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

DOCUMENTATION REQUIRED FOR MEDICAL REIMBURSEMENT

Prescription Medication

1. Completed OWCP-915

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

3. Proof of payment (can include cash receipt, cancelled check or credit card slip)

Medical Expense other than prescription medication

1. Completed OWCP-915
2. Physicians and other health care providers (i.e. physical therapists) must complete Form OWCP-1500. Hospitals and other facilities, such as ambulatory surgical centers, skilled nursing facilities, etc. must submit their bills on Form OWCP-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)

Return this completed claim form to the appropriate program address below.

Division of Federal Employees' Compensation (DFEC)	Division of Coal Mine Workers' Compensation (DCMWC)	Division of Energy Employees Occupational Illness Compensation (DEEOIC)
DFEC PO Box 8300 London, KY 40742-8300	DCMWC PO Box 8302 London, KY 40742-8302	DEEOIC PO Box 8304 London, KY 40742-8304 Or submit electronically via Energy Document Portal (EDP)

To receive payment, you must have electronic banking information (Electronic Funds Transfer or EFT) on file with the appropriate program to prevent a delay in the processing of your bills. Go To https://www.fiscal.treasury.gov/files/forms/form-1199a.pdf to download and complete the EFT form. Mail your completed claim form to the appropriate program below:

DFEC PO Box 8311 London, KY 40742-8311	DCMWC PO Box 8307 London, KY 40742-8307	DEEOIC PO Box 8306 London, Kentucky 40742-8306 Or submit electronically via Energy Document Portal (EDP)
If you have any questions regarding the completion of the form, please call Toll Free: 1-844-493-1966	If you have any questions regarding the completion of the form, please call Toll Free: 1-800-638-7072	If you have any questions regarding the completion of the form, please call Toll Free: 1-866-272-2682

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.

Burden Disclosure Notice

The public reporting burden for this data collection is estimated to average ten minutes per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and submitting the form. This collection of information is mandatory, as it is needed by OWCP and authorized by 5 USC 8101 et seq., 30 USC 901 et seq., and 42 USC 7384d to collect this information to administer the FECA, BLBA and EEOICPA. The information collected is used to identify the eligibility of the claimant for benefits, and to determine coverage of services provided. Please send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden, and reference OMB control number 1240-0007 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 (1240-0007), Washington, DC 20503. NOTE: Please do not send your completed form to this address.

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 furnish information regarding the medical service(s) received or the amount charged will prevent payment on 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 DOUGOVT-1, DOUESA-5, DOL/ESA-6, DOU ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOUESA-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.

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.