

# Enter Bills Online

Direct Data Entry (DDE)



# Introduction

This tutorial outlines the process to submit bills via Direct Data Entry (DDE) in the WCMBP Provider Portal. The following information will be covered:


- Submitting Bills in the WCMBP System
- Bill Submissions via DDE
  - Professional
  - Institutional
  - Dental
- Retrieving Saved Bills
- Adding Attachments After Bill Submission



# Submitting Bills in the WCMBP System (1 of 4)

How it works:

1. To access the **Existing User** login page, select the [WCMBP System](#) link. Enter the provider's email address and select **LOGIN**.



The screenshot displays the OWCP Connect login interface. At the top, a blue header bar contains the United States Department of Labor seal, the text 'United States Department of Labor Office of Workers' Compensation Programs', the OWCP logo, and a 'Help | FAQ' link. The main content area is divided into three columns. The left column, titled 'OWCP Connect', lists various user functions. The middle column, titled 'Existing User', provides a login form with an email address input field, a 'LOGIN' button, and links for password reset and email change. The right column, titled 'New User', offers a 'CREATE ACCOUNT' button and information for medical providers.

**OWCP Connect**

Once your identity is verified, you can enroll and login to OWCP's Medical Bill Processing Portal to:

- Look up a claimant's case number
- Find a claimant's accepted diagnosis code(s)
- Check eligibility for specific procedures
- Submit prior authorization requests
- Submit/resubmit bills and adjustments
- View payment status
- View correspondence
- Utilize Fee Schedule Calculator
- Maintain provider enrollment information
- Add additional users who can use the portal

**Existing User**

Login Using Email Address:

**LOGIN**

Forgot password?

**PASSWORD RESET**

Change Email?

**CHANGE EMAIL**

**New User**

First time using OWCP Connect?  
Create a new account here.

**CREATE ACCOUNT**

**Information for Medical Providers**

1. This process generally takes 3-5 minutes
2. Enrollment Tutorials ([Click Here](#))
3. Contact Us ([Click Here](#))

# Submitting Bills in the WCMBP System (2 of 4)

2. Enter the password and select **SUBMIT**.



United States Department of Labor  
Office of Workers' Compensation Programs



OWCP  
Office of Workers' Compensation Programs  
Protecting Injured Workers Responsibly and Compassionately

[Help](#) | [FAQ](#)

### Login

Welcome **Converted Provider1**. Please verify your security image and enter password.

Security Image



Key Phrase

tree

Password \*

\* Required Field

**SUBMIT**

### Instructions

Please make sure that the image and key phrase match what you selected and entered when you created your account.

Please enter a new password that meets the criteria listed below, and click SUBMIT.

**PASSWORD CRITERIA**

Passwords must be at least 8 characters long, composed of characters from the each of the following four categories:

- Uppercase letters (including, but not limited to A, B, C, Y, Z, etc.)
- Lowercase letters (including, but not limited to a, b, c, y, z, etc.)
- Special Characters (limited to #, ?, !, @, \$, %, ^, &, \*, -)
- Numbers (including, but not limited to, 1, 2, 3, 4, 5, etc.)


Passwords cannot contain the text of User ID, first name, last name or street address.

# Submitting Bills in the WCMBP System(3 of 4)

The system displays the default **Select a Provider ID Number to continue to the Provider Portal** page.

3. Select the applicable provider ID from the **Available Provider IDs** field and select **Go**.
4. Select **EXT Provider Bills Submitter** from the **Profile** drop-down list and select **Go**.

Welcome to the WCMBP Provider Portal




Select a Provider ID Number to continue to the Provider Portal:

Available Provider IDs:

*Users can toggle between multiple OWCP Provider IDs using the Switch OWCP Provider ID link on the Provider Portal.*

Welcome to the Workers' Compensation Medical Bill Process System



Select a profile to use during this session:

Profile:

# Submitting Bills in the WCMBP System(4 of 4)

5. Select the **On-line Bills Entry** link under **Bills**.

The screenshot displays the WCMBP System Provider Portal interface. At the top, a dark blue header bar contains the user profile 'Profile: EXT Provider Bills Submitter' and navigation links for 'External Links', 'Help', and 'Logout'. Below the header, a breadcrumb trail shows 'Provider Portal'. The left sidebar, titled 'Online Services', lists various functions under the 'Bills' category. The 'On-line Bills Entry' link is highlighted with a red rectangular box. Other links in the sidebar include 'Bill Inquiry', 'View Payment', 'Bill Adjustment', 'Resubmit Denied Bill', 'Retrieve Saved Bills', 'Manage Templates', 'Create Bills from Saved Templates', 'View Accounts Receivable', 'Fee Schedule Calculator', 'Claimant', 'Eligibility Inquiry', and 'Case Look-up'. The main content area features a 'ManageAlerts' button and a 'My Reminders' section. The 'My Reminders' section includes a filter bar with 'Filter By' dropdowns, a 'Read Status' dropdown, a 'Go' button, a 'Save Filter' button, and a 'My Filters' dropdown. Below the filter bar is a table with columns: 'Alert Type', 'Alert Message', 'Alert Date', 'Due Date', 'Read', and 'Attachment'. The table is currently empty, and a red message 'No Records Found!' is displayed in the center. At the bottom of the main content area, there is a 'Your Recent Online Activities' section with a checkmark icon.

Profile: EXT Provider Bills Submitter

External Links Help Logout

Provider Portal

Online Services

Bills

- Bill Inquiry
- View Payment
- Bill Adjustment
- On-line Bills Entry**
- Resubmit Denied Bill
- Retrieve Saved Bills
- Manage Templates
- Create Bills from Saved Templates
- View Accounts Receivable
- Fee Schedule Calculator

Claimant

- Eligibility Inquiry
- Case Look-up

ManageAlerts

My Reminders

Filter By : [dropdown] - [dropdown] Read Status [dropdown] Go Save Filter My Filters


	Alert Type ▲▼	Alert Message ▲▼	Alert Date ▲▼	Due Date ▲▼	Read ▲▼	Attachment ▲▼
No Records Found!						


Your Recent Online Activities

# Completing Bill Submission

The list of bill type options displays. Providers can now select the desired bill type to complete and submit for payment consideration.

**Note:** PROVIDER INFORMATION—to access and view the **Bill Submission** page after submitting a bill, providers must disable their popup blocker.

 > [Provider Portal](#) > [Bill Submission](#)

 Close

Choose an Option.	
<a href="#">Submit Professional</a> (OWCP-1500)	Submit Professional Use this option for services rendered by providers enrolled as Individual, Group or Ambulatory Surgical Centers.
<a href="#">Submit Institutional</a> (OWCP-04)	Submit Institutional Use this option for services rendered by providers enrolled as a facility.
<a href="#">Submit Dental</a>	Submit Dental



# Submitting a **Professional Bill** in the WCMBP System






# Submitting a Professional Bill in the WCMBP System

1. To begin entering a Professional claim using Direct Data Entry (DDE), select the **Submit Professional** link.

**Note:** PROVIDER INFORMATION—to access and view the **Bill Submission** page after submitting a bill, providers must disable their popup blocker.

 > [Provider Portal](#) > [Bill Submission](#)

 Close

Choose an Option.

<a href="#">Submit Professional</a> (OWCP-1500)	Submit Professional Use this option for services rendered by providers enrolled as Individual, Group or Ambulatory Surgical Centers.
<a href="#">Submit Institutional</a> (OWCP-04)	Submit Institutional Use this option for services rendered by providers enrolled as a facility.
<a href="#">Submit Dental</a>	Submit Dental

# Entering Provider Information – Professional (1 of 4)

1. Select the claimant program from the **Program** drop-down list for the bill being submitted.

**Note:** BILLING PROVIDER INFORMATION—such as Provider ID, Type, Provider Name, and Address—will display based on the provider profile of the user logged in. The provider is required to enter the National Provider ID (NPI) and is strongly encouraged to enter the billing Taxonomy code in the designated field.

2. To make changes to the Billing Provider address, select **+Address**. The **Address details** window opens.
  - a. Enter the address and zip code in the **Address Line 1** and **Zip Code** fields.
  - b. Select **Validate Address**. The remaining address fields automatically populate.
  - c. To return to the **Professional Bills Online Submission** page, select **OK**.

The screenshot displays the 'Professional Bill' form. The 'Basic Bill Info' tab is active, showing the 'Program' dropdown menu highlighted with a red box. Below this, the 'PROVIDER INFORMATION' section is visible. The 'NPI' field is highlighted with a red box. The 'Address Line 1' and 'Zip Code' fields are also highlighted with red boxes. The 'Validate Address' button is highlighted with a red box. The 'Address details' window is open, showing the 'Address Line 1' and 'Zip Code' fields highlighted with red boxes. The 'Validate Address' button is highlighted with a red box. The 'OK' button is highlighted with a red box.

# Entering Provider Information – Professional (2 of 4)

The **Is the Billing Location also the Service Facility Location** section automatically defaults to **No**.

3. Complete the **SERVICING FACILITY LOCATION** as applicable:

- If yes (the Billing Location is also the Service Facility Location), select **Yes**. The **SERVICING FACILITY LOCATION** grid collapses.
- If no (the Billing Location address differs from the practice address), complete the following:
  - a. Enter the Servicing Facility NPI in the **Servicing Facility Provider ID** field.
  - b. Select the NPI from the **Type** drop-down list.
  - c. To enter the Servicing Facility address:
    - i. Select **+Address**. The **Address details** window opens.
    - ii. Enter the address and zip code in the **Address Line 1** and **Zip Code** fields.
    - iii. Select **Validate Address**. The remaining address fields automatically populate.
    - iv. To return to the **Professional Bills Online Submission** page, select **OK**.

Is the Billing Location also the Service Facility Location? ☐ Yes ☒ No

**SERVICING FACILITY LOCATION**

Servicing Facility Provider ID:  Type:

Provider Name:

Address Line 1:  Address Line 2:

Address Line 3:

City/Town:  \*

State/Province:  \*

County:  \*

Country:  \*

Zip Code:  -

**Address details**

Address Line 1:  Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

City/Town:  \*

State/Province:  \*

County:  \*

Country:  \*


Zip Code:  -

# Entering Provider Information – Professional (3 of 4)

The **Is the Billing Provider also the Rendering Provider** section automatically defaults to **No**.

4. Complete the **Is the Billing Provider also the Rendering Provider** section as applicable:
- If yes (the Billing Provider is also the Rendering Provider), select **Yes**. The **RENDERING PROVIDER INFORMATION** section collapses.
  - If no (the Billing Provider differs from the Rendering Provider), complete the following:
    - a. Enter the Rendering Provider NPI in the **Provider ID** field.
    - b. Select the NPI from the **Type** drop-down list.

**Note:** Providers are encouraged to enter the **Taxonomy Code**.

 Is the Billing Provider also the Rendering Provider? ☐ Yes ☒ No

**RENDERING PROVIDER INFORMATION**

Provider ID:


Type:

Taxonomy Code:

# Entering Provider Information – Professional (4 of 4)

The **Is the Billing Provider also the Supervising Provider?** section automatically defaults to **Yes**.

5. Complete the **Is the Billing Provider also the Supervising Provider?** section.
  - If yes (the Billing Provider is also the Supervising Provider), proceed to the next step.
  - If no (the Billing Provider differs from the Supervising Provider), select **No**. The **SUPERVISING PROVIDER INFORMATION** section expands.
    - a. Enter the supervising provider's NPI in the **Provider ID** field.
    - b. Select **NPI** from the **Type** drop-down list.

 Is the Billing Provider also the Supervising Provider? ☐ Yes ☒ No

**SUPERVISING PROVIDER INFORMATION**

Provider ID:  Type:

The **Is the Service the result of a referral?** section automatically defaults to **No**.

6. Complete the **Is the Service the result of a referral?** section.
  - If no (the service is not a result of a referral), proceed to the next step.
  - If yes (the service is a result of a referral), select **Yes**. The **REFERRING PROVIDER INFORMATION** section expands.
    - a. Enter the referring provider's NPI in the **Provider ID** field.
    - b. Select **NPI** from the **Type** drop-down list.

 Is this service the result of a referral? ☒ Yes ☐ No

**REFERRING PROVIDER INFORMATION**

Provider ID:  Type:

# Entering Claimant Information

In this section, the provider will enter the necessary information about the claimant. Some fields are optional; the mandatory fields have an asterisk (\*).

1. Complete the **Claimant ID** field.
2. Select **Case Number** from the **Type** drop-down list.

**Note:** FECA, DCMWC, and DEEOIC can enter a social security number (SSN) or Case Number. If an SSN is entered for a FECA claimant, the **Date of Injury** field is required.

**Note:** If claimant information is found based on Type (Case Number or SSN), the system will auto-populate the claimant's information. If the system cannot locate claimant information, the system will display a message stating, "CLAIMANT INFORMATION—Claimant details not found for the program selected". Providers will need to manually enter the claimant information.

The screenshot shows a web form titled "CLAIMANT INFORMATION". The form is divided into two main sections: "CLAIMANT" and "Type". The "CLAIMANT" section contains the following fields:

- Claimant ID: A text input field with an asterisk (\*) indicating it is mandatory. It is highlighted with a red box.
- Date of Injury: A date selection field with MM, DD, and CCYY components. It has an asterisk (\*) and a note: "(Required when SSN is keyed in to submit bill for DFEC Claimant)".
- Last Name: A text input field with an asterisk (\*) indicating it is mandatory.
- Middle Name: A text input field.
- Date of Birth: A date selection field with MM, DD, and CCYY components. It has an asterisk (\*) indicating it is mandatory.
- Date of Death: A date selection field with MM, DD, and CCYY components.
- Zip Code: A text input field.

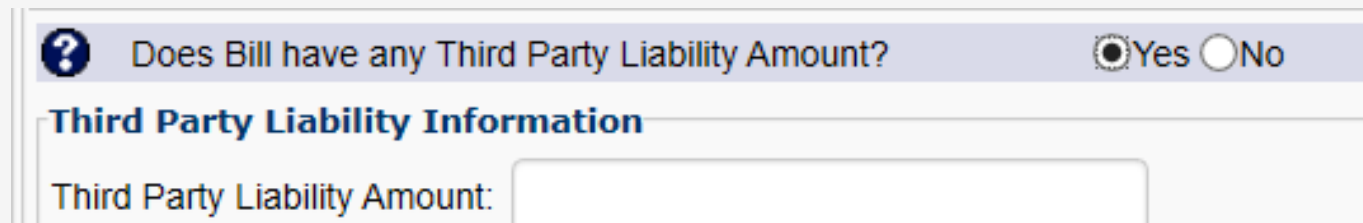
The "Type" section contains the following fields:

- Type: A drop-down menu with an asterisk (\*) indicating it is mandatory. It is highlighted with a red box.
- First Name: A text input field with an asterisk (\*) indicating it is mandatory.
- Suffix: A text input field.
- State/Province: A drop-down menu with an asterisk (\*) indicating it is mandatory.

# Entering Third Party Liability Amount

The **Does Bill have any Third-Party Liability Amount?** section (Professional bill section) automatically defaults to **No**.

1. Complete the **Does Bill have any Third-Party Liability Amount?** section as applicable:
  - If no (the bill does not include Third-Party Liability (TPL) amount), proceed to the next step.
  - If yes (there is a TPL amount to be listed), select **Yes** and enter the amount that was paid by a Third-Party Liability (TPL) in the **Third Party Liability Amount** field.



The screenshot shows a form section with a header bar containing a question mark icon, the text "Does Bill have any Third Party Liability Amount?", and two radio buttons labeled "Yes" and "No". Below the header bar is a section titled "Third Party Liability Information" in blue. Under this section is a label "Third Party Liability Amount:" followed by an empty text input field.



# Entering Bill Information – Professional (1 of 6)

The following slides guide providers through completing the **Bill Information** section. The sub-headings that have a plus icon (+) next to them are expandable. When the provider selects the plus icon (+), the provider can enter information as needed in the expanded subsection.

When a subsection expands, fields with an asterisk (\*) are mandatory. To collapse a subsection without including any additional information, providers can select the minus icon (–).

The following fields default as optional until the provider expands them:

- Relevant Dates
- Bill note
- Anesthesia related procedure
- Condition information
- Delay reason

The screenshot displays the 'BILL INFORMATION' form with the following sections and fields:

- BILL INFORMATION** (Section Header)
- + RELEVANT DATES** (Expandable Section)
- PRIOR AUTHORIZATION** (Section Header)
  - Prior Authorization Number: [Text Field]
- + BILL NOTE** (Expandable Section)
  - Is this bill accident related? ☒ Yes ☐ No
- RELATED CAUSES INFORMATION** (Section Header)
  - Related Causes: 1 [Dropdown Menu] \* 2 [Text Field]
  - Auto Accident State: [Dropdown Menu] Auto A
- BILL DATA** (Section Header)
  - Patient Account No.: [Text Field]
  - Place of Service: [Dropdown Menu] \*
- Diagnosis Codes (Do not use decimals or spaces)** (Section Header)
  - Diagnosis Code Category: [Dropdown Menu] \*
  - Diagnosis Codes: 1: [Text Field] \* 2: [Text Field]
  - 7: [Text Field] 8: [Text Field]
- + ANESTHESIA RELATED PROCEDURE** (Expandable Section)
- + CONDITION INFORMATION** (Expandable Section)
- + DELAY REASON** (Expandable Section)

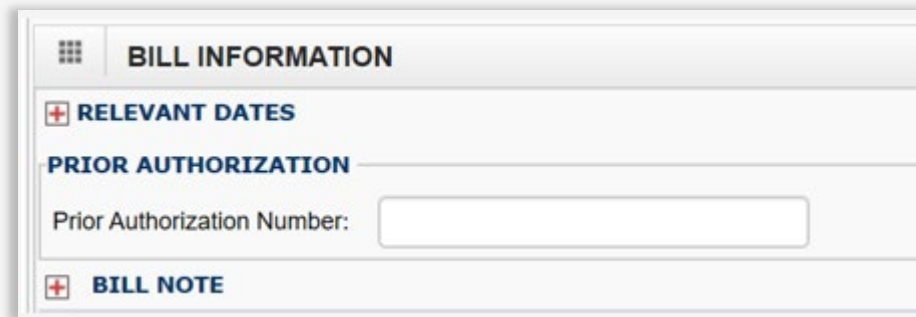
# Entering Bill Information – Professional(2 of 6)

In this section, the provider may enter additional bill information pertaining to the service provided to the claimant.

1. If applicable, complete the following:

- **RELEVANT DATES**
- **Prior Authorization Number**
- **BILL NOTE**

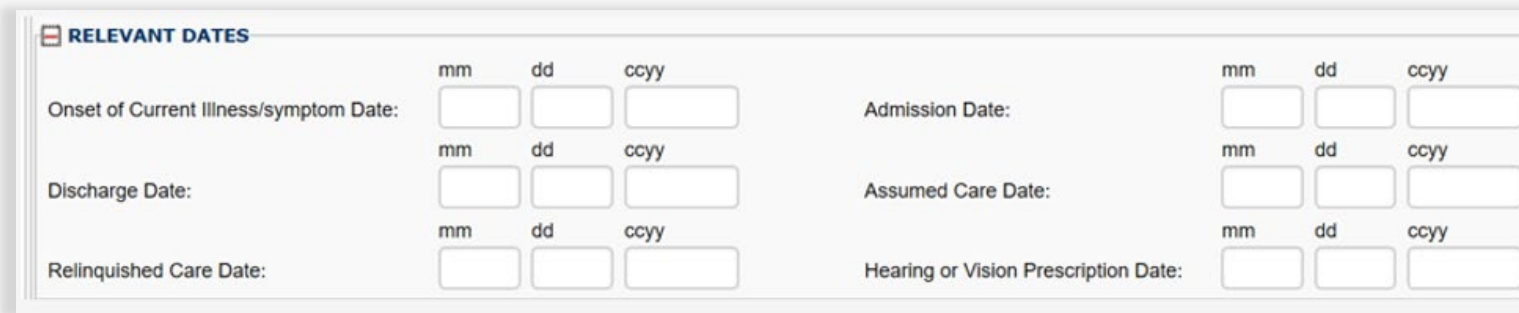
**Note:** To enter Relevant Dates or a Bill Note, the provider must select the plus icon (+). The minus icon (–) can be used to collapse it if it is no longer needed.



The screenshot shows a web form titled "BILL INFORMATION" with a grid icon in the top left corner. Below the title, there are three expandable sections, each with a red plus icon (+) to its left. The first section is "RELEVANT DATES". The second section is "PRIOR AUTHORIZATION", which contains a text label "Prior Authorization Number:" followed by an empty rectangular input field. The third section is "BILL NOTE".

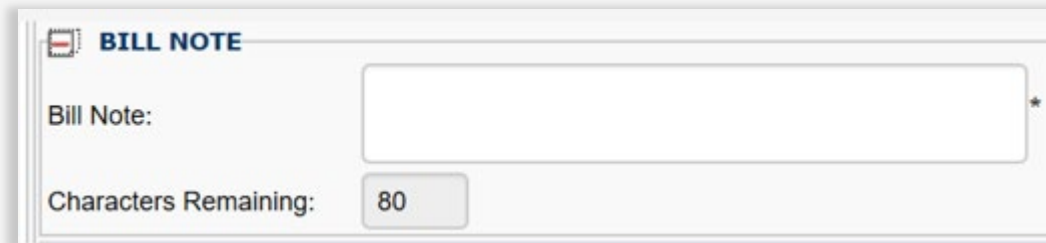
# Entering Bill Information – Professional(3 of 6)

2. In the **RELEVANT DATES** section, enter **Relevant Dates** related to the services.



The screenshot shows a form section titled "RELEVANT DATES" with a red minus icon in the top left corner. It contains six date input fields arranged in two columns. Each field is labeled with its purpose and has three sub-inputs for month (mm), day (dd), and year (ccyy). The labels and their corresponding sub-inputs are: "Onset of Current Illness/symptom Date:" (mm, dd, ccyy), "Discharge Date:" (mm, dd, ccyy), "Relinquished Care Date:" (mm, dd, ccyy), "Admission Date:" (mm, dd, ccyy), "Assumed Care Date:" (mm, dd, ccyy), and "Hearing or Vision Prescription Date:" (mm, dd, ccyy).

3. Within the **BILL NOTE** section, enter a bill note related to the services in the **Bill Note** field.



The screenshot shows a form section titled "BILL NOTE" with a red minus icon in the top left corner. It features a large text area for the "Bill Note:" and a "Characters Remaining:" indicator showing "80".

**Note:** Providers can enter up to 80 characters in this field.

# Entering Bill Information – Professional(4 of 6)

The **Is this bill accident related?** section automatically defaults to **No**.

4. Complete the **Is the bill accident related?** section as applicable:
  - If no (the bill is not accident related), proceed to the next step.
  - If yes (the bill is accident related), select **Yes**. The **Related Causes Information** section expands.
    - a. Select the related cause or causes (AA-Auto Accident, EM-Employment, or OA-Other Accident) from the **Related Causes** drop-down list.
    - b. Enter the accident date in the **Accident Date** field.

The screenshot shows a form section titled "Is this bill accident related?" with radio buttons for "Yes" (selected) and "No". Below this is the "RELATED CAUSES INFORMATION" section. It contains two dropdown menus for "Related Causes" labeled "1" and "2". Below these are fields for "Auto Accident State" (a dropdown), "Auto Accident Country" (set to "US"), and "Accident Date" (three separate boxes for month, day, and year, labeled "mm", "dd", and "ccyy" respectively). The "Accident Date" field is marked with an asterisk.

5. Enter the patient account number within the provider's organization in the **Patient Account No.** field.
6. Select the place of service from the **Place of Service** drop-down list.

The screenshot shows a form section titled "BILL DATA". It contains two fields: "Patient Account No." with a text input box, and "Place of Service" with a dropdown menu. The "Place of Service" field is marked with an asterisk.

# Entering Bill Information – Professional(5 of 6)

7. Select the diagnosis code category (ICD-9 or ICD-10) based on the date of service from the **Diagnosis Code Category** drop-down list and enter the appropriate diagnosis codes in the **Diagnosis Codes** fields.

**Note:**

- At least one Diagnosis Code is required
- Providers must list all ICD-9 or ICD-10 codes based on the date of service (DOS)
- Providers must list ICD Codes in sequential order, one through 12 (do not skip a number)
- ICD-9 Diagnosis Codes (applies if DOS is on or prior to September 30, 2015)
- ICD-10 Diagnosis Codes (applies if DOS is on or after October 1, 2015)

Diagnosis Code Category:	<input type="text" value="ICD-9-CM"/> *												
Diagnosis Codes:	1:	<input type="text"/>	*	2:	<input type="text"/>	3:	<input type="text"/>	4:	<input type="text"/>	5:	<input type="text"/>	6:	<input type="text"/>
	7:	<input type="text"/>		8:	<input type="text"/>	9:	<input type="text"/>	10:	<input type="text"/>	11:	<input type="text"/>	12:	<input type="text"/>
<input checked="" type="checkbox"/> ANESTHESIA RELATED PROCEDURE													
<input checked="" type="checkbox"/> CONDITION INFORMATION													
<input checked="" type="checkbox"/> DELAY REASON													

# Entering Bill Information – Professional (6 of 6)

The **ANESTHESIA RELATED PROCEDURE**, **CONDITION INFORMATION**, and **DELAY REASON** expandable sub-headings are optional. Providers can select the plus icon (+) to add an Anesthesia Related Procedure, Condition Information, or a Delay Reason, and they can select the minus icon (–) to collapse it if it is no longer needed.

8. In the **ANESTHESIA RELATED PROCEDURE** section, complete the **Principle HCPCS Code** field.

9. In the **CONDITION INFORMATION** section, complete the **Condition Code** field.

**Note:** To add another condition code, providers can select the **Add Another** link.

10. In the **DELAY REASON** section, select an option from the **Delay Reason Code** drop-down list.

The screenshot displays a web form for entering bill information. It features three expandable sections: **ANESTHESIA RELATED PROCEDURE**, **CONDITION INFORMATION**, and **DELAY REASON**. Each section has a minus icon in a red box to its left. The **ANESTHESIA RELATED PROCEDURE** section contains two text input fields: 'Principle HCPCS Code:' and 'Other HCPCS Code:'. The **CONDITION INFORMATION** section contains a 'Condition Code:' field with a plus icon and an 'Add Another' link. The **DELAY REASON** section contains a 'Delay Reason Code:' dropdown menu. A dropdown list is open, showing various delay reasons. A 'Top' link is located in the bottom right corner of the form area.

Section	Field	Value / Options
ANESTHESIA RELATED PROCEDURE	Principle HCPCS Code:	
	Other HCPCS Code:	
CONDITION INFORMATION	Condition Code:	
	Add Another	Link
DELAY REASON	Delay Reason Code:	1-Proof of Eligibility Unknown or Unavailable 10-Administration Delay in the Prior Approval Process 11-Other 15-Natural Disaster 2-Litigation 3-Authorization Delays 4-Delay in Certifying Provider 5-Delay in Supplying Billing Forms 6-Delay in Delivery of Custom Made Appliances 7-Third Party Processing Delay 8-Delay in Eligibility Determination 9-Claim Denied Unrelated to Billing Limitation Rules

# Entering Basic Line Item Information – Professional (1 of 8)

1. Enter the date of service range in the **Service Date From** and **Service Date To** fields.
2. Select a place of service (POS) from the **Place of Service (if different from header)** drop-down list (two-digit POS code representing where services are rendered, if different than the POS selected in the **Bill information** section).

The screenshot shows a web form titled "BASIC LINE ITEM INFORMATION". A red rectangular box highlights the "BASIC SERVICE LINE ITEMS" section, which contains the following fields:

- Service Date From:** A date input field with labels "mm", "dd", and "ccyy" above the input boxes.
- Service Date To:** A date input field with labels "mm", "dd", and "ccyy" above the input boxes.
- Place of Service (if different from header):** A drop-down menu.

Below the highlighted section, the form includes several other fields:

- Procedure Code:** A text input field with an asterisk.
- Submitted Charges: \$:** A text input field with an asterisk.
- Units/Quantity:** A text input field with an asterisk.
- Third Party Liability Amount:** A text input field.
- EMG:** A drop-down menu.
- Bill Note:** A large text area.
- Characters Remaining:** A small box showing "500".
- Prior Authorization Number:** A text input field.
- Rendering Provider ID (if different from header):** A text input field.
- Ordering Provider ID:** A text input field.
- Referring Provider ID (if different from header):** A text input field.
- Type:** A drop-down menu, currently showing "NPI".
- Taxonomy Code:** A text input field.



# Entering Basic Line Item Information – Professional (2 of 8)

**Note:** The following two steps are for procedures, services, or supplies.

3. Enter the five-character HCPCS or CPT code in the **Procedure Code** field, if applicable.
4. Enter the two-digit modifier in the **Modifiers** fields, if applicable.

**BASIC LINE ITEM INFORMATION**

**BASIC SERVICE LINE ITEMS**

Service Date From: mm dd ccyy Service Date To: mm dd ccyy

Place of Service (If different from header):

**Procedure Code:** \* **Modifiers:** 1: 2: 3: 4:

Submitted Charges: \$: \* Diagnosis Pointers: 1: 2: 3: 4:

Units/Quantity: \*

Third Party Liability Amount:

EMG:

Bill Note:

Characters Remaining: 500

Prior Authorization Number:

Rendering Provider ID (If different from header): Type: NPI Taxonomy Code:

Ordering Provider ID: Type:

Referring Provider ID (If different from header): Type:

# Entering Basic Line Item Information – Professional (3 of 8)

5. Enter the submitted charges for the line item in the **Submitted Charges** field.
6. In the **Diagnosis Pointers** fields, enter the diagnostic reference number (one through 12 from the **Bill Information** section) to associate the Date of Service (DOS) and the procedure with the corresponding diagnosis).

The screenshot shows a web form titled "BASIC LINE ITEM INFORMATION". The form contains several sections for data entry. The "BASIC SERVICE LINE ITEMS" section includes fields for "Service Date From" and "Service Date To" (each with mm, dd, ccyy sub-fields), "Place of Service (If different from header)" (a dropdown), "Procedure Code" (a text field with an asterisk), "Modifiers" (four numbered text fields), "Submitted Charges: \$" (a text field with an asterisk, highlighted with a red box), "Diagnosis Pointers" (four numbered dropdown menus, also highlighted with a red box), "Units/Quantity" (a text field with an asterisk), "Third Party Liability Amount" (a text field), "EMG" (a dropdown), and "Bill Note" (a large text area). Below this is a "Characters Remaining" indicator showing 500. The bottom section includes "Prior Authorization Number" (a text field), "Rendering Provider ID (If different from header)" (a text field), "Ordering Provider ID" (a text field), and "Referring Provider ID (If different from header)" (a text field). To the right of these are "Type" dropdowns and a "Taxonomy Code" text field. The "Submitted Charges" and "Diagnosis Pointers" fields are highlighted with a red rectangular box.

# Entering Basic Line Item Information – Professional (4 of 8)

7. In the **Units/Quantity** field, enter the number of units provided during the date of service range entered.
8. In the **Third Party Liability Amount** field, enter the amount that was paid by a Third-Party Liability (TPL).  
**Note:** DOL is primary, leave blank. If listed, monies will be deducted from the allowed reimbursement amount.

The screenshot shows a web form titled "BASIC LINE ITEM INFORMATION". The form is divided into several sections. The "BASIC SERVICE LINE ITEMS" section contains the following fields:

- Service Date From: mm dd ccyy (with asterisks indicating required fields)
- Service Date To: mm dd ccyy (with asterisks indicating required fields)
- Place of Service (If different from header): dropdown menu
- Procedure Code: text input field with an asterisk
- Submitted Charges: \$: text input field with an asterisk
- Units/Quantity: text input field with an asterisk (highlighted with a red box)
- Third Party Liability Amount: text input field (highlighted with a red box)
- EMG: dropdown menu
- Bill Note: text area
- Characters Remaining: 500
- Prior Authorization Number: text input field
- Rendering Provider ID (If different from header): text input field
- Ordering Provider ID: text input field
- Referring Provider ID (If different from header): text input field
- Type: dropdown menu (selected value is "NPI")
- Taxonomy Code: text input field

The "Units/Quantity" and "Third Party Liability Amount" fields are highlighted with a red box, indicating they are the focus of the current step.

# Entering Basic Line Item Information – Professional (5 of 8)

9. If applicable, select **Yes** or **No** from the **EMG** drop-down list to identify if this an emergency service. (Optional)
10. If applicable, enter a bill note (up to 500 characters) in the **Bill Note** field. (Optional)

The screenshot shows a web form titled "BASIC LINE ITEM INFORMATION". The form contains several input fields and dropdown menus. A red rectangular box highlights the "EMG:" dropdown menu and the "Bill Note:" text area. Below the "Bill Note:" field, it says "Characters Remaining: 500". At the bottom of the form, there are fields for "Prior Authorization Number:", "Rendering Provider ID (If different from header):", "Ordering Provider ID:", and "Referring Provider ID (If different from header):", each followed by a "Type:" dropdown menu. To the right of these is a "Taxonomy Code:" field.

**BASIC LINE ITEM INFORMATION**

**BASIC SERVICE LINE ITEMS**

Service Date From: mm dd ccyy \* Service Date To: mm dd ccyy \*

Place of Service (If different from header): \*

Procedure Code: \* Modifiers: 1: 2: 3: 4: \*

Submitted Charges: \$: \* Diagnosis Pointers: 1: 2: 3: 4: \*

Units/Quantity: \*

Third Party Liability Amount: \*

EMG: \*

Bill Note: \*

Characters Remaining: 500

Prior Authorization Number: \*

Rendering Provider ID (If different from header): \* Type: NPI Taxonomy Code: \*

Ordering Provider ID: \* Type: \*

Referring Provider ID (If different from header): \* Type: \*

# Entering Basic Line Item Information – Professional (6 of 8)

11. Complete the **Prior Authorization Number** field as applicable:

- If the prior authorization number is the same as the header provider information, then leave blank.
- If the prior authorization number differs from the header provider information input during the **Provider Information** section, enter a prior authorization number in the **Prior Authorization Number** field.

Prior Authorization Number:	<input type="text"/>		
Rendering Provider ID (If different from header):	<input type="text"/>	Type: <input type="text"/>	Taxonomy Code: <input type="text"/>
Ordering Provider ID:	<input type="text"/>	Type: <input type="text"/>	
Referring Provider ID (If different from header):	<input type="text"/>	Type: <input type="text"/>	

12. Complete the following fields as applicable:

- If the rendering provider, ordering provider, or referring provider is the same as the header provider information, then leave blank.
- If the rendering provider, ordering provider, or referring provider differ from the header provider information input during the **Provider Information** section, enter the National Provider ID (NPI) in the **Rendering Provider ID**, **Ordering Provider ID**, or **Referring Provider ID** field and select **NPI** from the **Type** drop-down list.

**Note:** If a rendering provider NPI is submitted, providers are encouraged to also enter the appropriate taxonomy code.

Prior Authorization Number:	<input type="text"/>		
Rendering Provider ID (If different from header):	<input type="text"/>	Type: <input type="text"/>	Taxonomy Code: <input type="text"/>
Ordering Provider ID:	<input type="text"/>	Type: <input type="text"/>	
Referring Provider ID (If different from header):	<input type="text"/>	Type: <input type="text"/>	

# Entering Basic Line Item Information – Professional (7 of 8)

The **Is the Header Service Facility Location** section defaults to **Yes**.

13. Is the header service facility location also the service line facility location?

- If yes, leave as is and proceed to the next step.
- If no (the service line facility location is different from the Header Service Facility Location in the **Billing Provider Information** section), select **No**. A dialogue box expands to add the Service Line Facility Location information.

- Enter the servicing facility provider ID in the **Provider ID** field.
- Select **NPI** from the **Type** drop-down list.
- Select **+Address**. The **Address details** window opens.
- To enter the servicing facility location address, complete the **Address Line 1** and **Zip Code** fields, then select **Validate Address**. The other address fields automatically populate.
- Select **OK** to return to the **Professional Bills Online Submission** page.

Is the Header Service Facility Location also the Service Line Facility Location? ☐ Yes ☒ No

**Servicing Facility Location**

Provider ID:  Type:

Provider Name:

Address Line 1:  \* Address Line 2:

Address Line 3:

City/Town:  \* State/Province:  \*

County:  \* Country:  \*

Zip Code:  -  **+ Address**

**Address details**

Address Line 1:  \* Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

City/Town:  \* State/Province:  \*

County:  \* Country:  \*

Zip Code:  -  **Validate Address**

**OK** **Cancel**

# Entering Basic Line Item Information – Professional (8 of 8)

14. Complete the **LINE DRUG INFORMATION** section as applicable:

- To add **Line Drug Information**, select the plus icon (+).
- If this section is no longer needed, select the minus icon (–) to collapse it.

Prior Authorization Number:   
Rendering Provider ID (If different from header):  Type:  Taxonomy Code:   
Ordering Provider ID:  Type:   
Referring Provider ID (If different from header):  Type:   
Is the Header Service Facility Location also the Service Line Facility Location? ☒ Yes ☐ No  
**LINE DRUG INFORMATION**  
Add Service Line Item Update Service Line Item  
National Drug Code:  \* Quantity:  \* Unit:  \*  
Qualifier:  Prescription/Link No:  Prescription Date:  mm  dd  ccyy

15. To include the line item in the bill, select **Add Service Line Item**. Repeat this process for each additional line. A window displays to confirm the Service Line is added successfully.

16. Select **OK** to close the window.

**Note:** Providers can select **Update Service Line Item** to make corrections and enter missing information to a line item that was previously added.

Prior Authorization Number:   
Rendering Provider ID (If different from header):  Type:  Taxonomy Code:   
Ordering Provider ID:  Type:   
Referring Provider ID (If different from header):  Type:   
Is the Header Service Facility Location also the Service Line Facility Location? ☒ Yes ☐ No  
**LINE DRUG INFORMATION**  
Add Service Line Item Update Service Line Item



# Previously Entered Line Item Information – Professional

Once a line item has been added, the line item information displays.

1. Proceed with the line item information as follows:
  - To update the line item information, select the **Line No** link.
  - To remove the line item, select the **Delete** link.

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: \$ 100.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	02/01/2020	02/01/2020	25109									\$ 100.00	1		Delete

2. Once the provider enters all line items, scroll back to the top of the page and select **Submit Bill** to submit the bill.

**Note:** The provider also has the option to save the bill and return later or reset the bill to start over. To view the steps on retrieving a saved bill, proceed to the [Retrieving Saved Bills](#) section of this document.



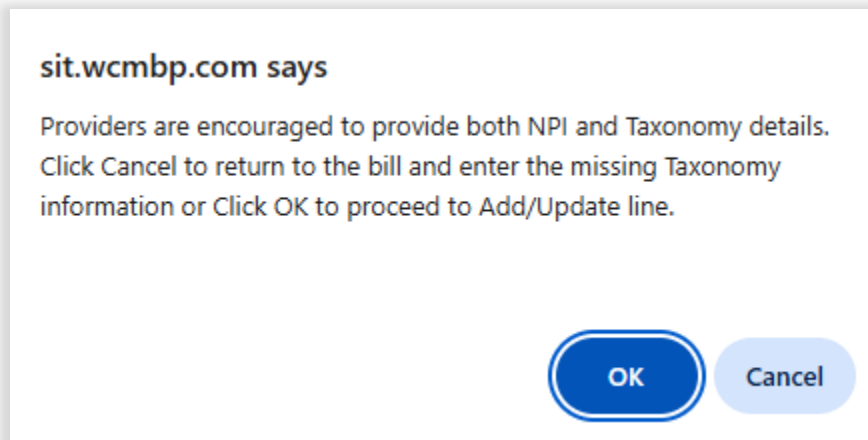
**Note:** Saved bills are available under the **Retrieve Saved Bills** menu for a later submission.

# Bill Information – Add or Update Service Line Warning

If the provider enters one item (rendering provider NPI or rendering taxonomy code), the other item is recommended to be entered. The system will return a message indicating that both items are encouraged.

When this system message is received, proceed as applicable:

- To return to the bill and enter the missing taxonomy, select **Cancel**.
- To proceed to add or update the line, select **OK**.

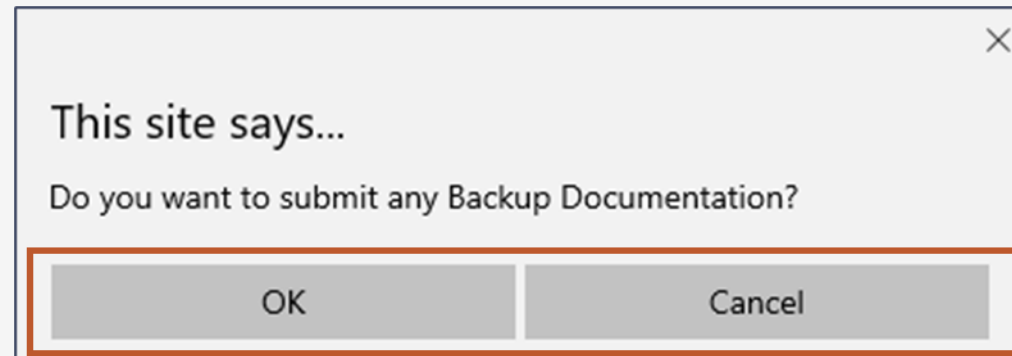


# Adding an Attachment – Professional (1 of 3)

When selecting **OK** to proceed to add or update the line, a popup window opens with the message "Do you want to submit any Backup Documentation?"

1. Proceed as applicable:

- To add attachments, select **OK**. The **Add Attachments** window opens.
- To proceed without attachments (no attachment is needed), select **Cancel**. The submitted professional bill details display.



# Adding an Attachment – Professional (2 of 3)

- In the **Add Attachments** window, select the **Attachment Type** being submitted for the services rendered and select the **Transmission Code**.

**Note:** Attachments can only be attached if selecting Transmission Code of **EL** or **FT**.

Please select one of the option from the Required Fields \* and select Line No, if the attachment is for specific Service Line Item.

**Attachment Type:** 03-03-Report Justifying Treatment & \* **Transmission Code:** EL-Electronically Only \*

Line No: (Do not select Line No to attach a document at header level)

**Please attach the File(s). The File Format must be PDF, TIF, TIFF**

Upload File \*

Please be sure the supporting documentation/attachments is for the treated claimant ONLY.  
Please do not upload supporting documentation/attachments for any other claimant as this could potentially cause a denial of your bill or an unintended disclosure of protected health information (PHI).

OK Cancel

AA-Available on Request at Provid  
BM-By Mail  
EL-Electronically Only  
EM-E-Mail  
FT-FT-File Transfer  
FX-By-Fax

- To locate and add the attachment, select **Upload File**, then select **OK**.

Please select one of the option from the Required Fields \* and select Line No, if the attachment is for specific Service Line Item.

**Attachment Type:** 03-03-Report Justifying Treatment & \* **Transmission Code:** EL-Electronically Only \*

Line No: (Do not select Line No to attach a document at header level)

**Please attach the File(s). The File Format must be PDF, TIF, TIFF**

Upload File \*

Please be sure the supporting documentation/attachments is for the treated claimant ONLY.  
Please do not upload supporting documentation/attachments for any other claimant as this could potentially cause a denial of your bill or an unintended disclosure of protected health information (PHI).

OK Cancel

# Adding an Attachment – Professional (3 of 3)

Once the **Submit Bill** tab is selected, the Transaction Control Number (TCN) displays and the option to add additional attachments displays. Once the attachment is added, it will be listed in the **Attachment List** section.

4. To complete the physician or supplier attestation, select the **SIGNATURE OF PHYSICIAN OR SUPPLIER** checkbox.

Submitted Professional Bill Details

The 'Submit' button must be clicked to send the Bill for processing. If not, the Bill will be available under 'Retrieve Saved Bills' menu for later submission.

Transaction Control Number (TCN):   
Provider ID:   
Claimant ID:   
Date of Service: 10/31/2023-10/31/2024  
Total Bill Charges: \$ 600.00

☐ **SIGNATURE OF PHYSICIAN OR SUPPLIER**

Checking this box 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). Checking this box 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, BLBA 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 acknowledgement indicates that you understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Please click "Add Attachment" button, to attach the documents.

Add Attachment

Attachment List

<input type="checkbox"/>	Line No ▲▼	File Name ▲▼	Attachment Type ▲▼	Transmission Code ▲▼	Attachment Control # ▲▼	File Size ▲▼	Delete ▲▼	Uploaded On ▲▼
<input type="checkbox"/>	1	Supporting Document.pdf	03	EL	201446514	27kb	X	05/07/2025

View Page: 1

Go

Page Count

Viewing Page: 1

First

Prev

Next

Last

Print

Print Cover Page

Submit

SaveToCSV

# Submitted Professional Bill Details

5. To submit the bill, select **Submit**. Once submitted, the “Do you want to Submit another Bill?” confirmation alert message displays.



**Important:** For transmission codes of AA, BM, EM, and FX, the provider will need to select **Print Cover Page** to mail or fax the attachments. Refer to [How to View PDFs Using Adobe Reader](#) for instructions on how to view PDFs using Adobe Reader.

Submitted Professional Bill Details

The 'Submit' button must be clicked to send the Bill for processing. If not, the Bill will be available under 'Retrieve Saved Bills' menu for later submission.

Transaction Control Number (TCN):   
Provider ID:   
Claimant ID:   
Date of Service: 10/31/2023-10/31/2024  
Total Bill Charges: \$ 600.00

☐ **SIGNATURE OF PHYSICIAN OR SUPPLIER**

Checking this box 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). Checking this box 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, BLBA 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 acknowledgement indicates that you understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Please click "Add Attachment" button, to attach the documents.

Add Attachment

Attachment List

<input type="checkbox"/>	Line No ▲▼	File Name ▲▼	Attachment Type ▲▼	Transmission Code ▲▼	Attachment Control # ▲▼	File Size ▲▼	Delete ▲▼	Uploaded On ▲▼
<input type="checkbox"/>	1	Supporting Document.pdf	03	EL	201446514	27kb	X	05/07/2025

View Page: 1 Go + Page Count

Viewing Page: 1

Save To CSV

Print

Print Cover Page

Submit

# Missing Data Message – Professional

Most billing providers are required to include the Billing NPI. For OWCP bills submitted from providers such as non-medical vendors, fiscal intermediaries, and non-emergency transportation, Billing NPI is not required.

- If the **NPI** is missing, an error message will display.

The following is required information that the provider may be prompted to enter:

- Billing Provider Information – NPI
- If the **Taxonomy Code** is missing or invalid, a warning message will display.
  - Providers are encouraged to submit taxonomy details for Billing Provider and NPI or taxonomy details for Rendering Provider at header and lines.
  - Review the following missing NPI or taxonomy information:
    - Billing Provider Information - Taxonomy Code
    - Rendering Provider - Taxonomy Code
    - Line Rendering Provider - Taxonomy Code for Lines

**Note:** The provider can select **Cancel** to return to the bill and enter the details or they can select **OK** to proceed with submission.



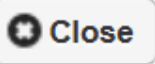
## Submitting an **Institutional Bill** in the WCMBP System



# Submitting an Institutional Bill in the WCMBP System

1. To begin entering an Institutional claim using Direct Data Entry (DDE), select the **Submit Institutional** link.

**Note:** PROVIDER INFORMATION — To access and view the **Bill Submission** page after submitting a bill, providers must disable their popup blocker.

 Close

Choose an Option.	
<a href="#">Submit Professional</a> (OWCP-1500)	Submit Professional Use this option for services rendered by providers enrolled as Individual, Group or Ambulatory Surgical Centers.
<a href="#">Submit Institutional</a> (OWCP-04)	Submit Institutional Use this option for services rendered by providers enrolled as a facility.
<a href="#">Submit Dental</a>	Submit Dental

# Provider Information – Institutional

1. To select the program of the claimant for which the bill is being submitted, select from the **Program** drop-down list.

**Note:** Billing Provider information – such as Provider ID and Type — will display based on the provider profile of the user logged in. The provider is required to enter the National Provider ID (**NPI**) and is encouraged to enter the **Taxonomy Code** in the designated field when required by the selected provider type. If the provider type requires a Medicare Number, the provider will enter it in the **Medicare Number** field.

2. Enter the Attending Provider NPI number in the **Provider ID** field. When attending NPI is entered, it is encouraged to enter the Taxonomy Code.

**Note:** The Attending Provider is the doctor overseeing the patient's general and treatment care.


The screenshot displays a web form titled "Institutional Bill". At the top, a note states: "Note: asterisks ( \* ) denote required fields." Below this is a tabbed interface with "Basic Bill Info" selected. Under this tab, there is a "Program:" dropdown menu with a red border and an asterisk, and a "Special Bill Indicator:" dropdown menu set to "NONE". To the right is a "Submitter ID:" field. Below the "Basic Bill Info" section is the "PROVIDER INFORMATION" section. It contains two sub-sections: "BILLING PROVIDER INFORMATION" and "ATTENDING PROVIDER INFORMATION". In the "BILLING PROVIDER INFORMATION" section, there are fields for "Provider ID:" (with a red border), "Type:" (a dropdown menu showing "OWCP ID"), "NPI:" (with a red border), "Medicare Number:" (a text field), and "Taxonomy Code:" (with a red border). The "ATTENDING PROVIDER INFORMATION" section has fields for "Provider ID:" (with a red border), "Type:" (a dropdown menu), and "Taxonomy Code:" (a text field).

# Claimant Information – Institutional(1 of 2)


1. Enter the **Claimant ID**.
2. Select the case number from the **Type** drop-down list.

**Note:** FECA, DCMWC, and DEEOIC can enter SSN or Case Number. If SSN is entered for a FECA claimant, the **Date of Injury** field is required.

**Note:** If claimant information is found based on Type (Case Number or SSN), the system will auto-populate the claimant's information. If the system cannot locate claimant information, the system will display a message stating, "CLAIMANT INFORMATION—Claimant details not found for the program selected." The Provider will need to manually enter the claimant information.



CLAIMANT INFORMATION



CLAIMANT

Claimant ID: \*

Type: \*

Date of Injury: 

MM \*

DD \*

CCYY \*

(Required when SSN is keyed in to submit bill for DFEC Claimant)

Last Name: \*

First Name: \*

Middle Name:

Suffix:

Date of Birth: 

MM \*

DD \*

CCYY \*

State/Province:

Zip Code:

# Claimant Information – Institutional (2 of 2)

The **Does Bill have any Third Party Liability Amount** section defaults to **No**.

3. Complete the **Does Bill have any Third-Party Liability Amount** section as applicable:

- If no (the bill does not include Third-Party Liability (TPL) amount), proceed to the next step.
- If yes (there is a TPL amount to be listed), select **Yes** and enter the amount that was paid by a Third-Party Liability (TPL) in the **Third Party Liability Amount** field.

CLAIMANT INFORMATION			
<b>CLAIMANT</b>			
Claimant ID:	<input type="text"/>	Type:	<input type="text"/>
Date of Injury:	<input type="text"/>	<input type="text"/>	<input type="text"/>
	MM	DD	CCYY
			(Required when SSN is keyed in to submit bill for DFEC Claimant)
Last Name:	<input type="text"/>	First Name:	<input type="text"/>
Middle Name:	<input type="text"/>	Suffix:	<input type="text"/>
Date of Birth:	<input type="text"/>	<input type="text"/>	<input type="text"/>
	MM	DD	CCYY
State/Province:	<input type="text"/>	Zip Code:	<input type="text"/>
<input type="checkbox"/> Does Bill have any Third Party Liability Amount? <input type="radio"/> Yes <input checked="" type="radio"/> No			

# Bill Information – Institutional (1 of 12)

## Enter the following bill information:

1. In the **Patient Account No.** field, enter the patient's account number within the provider's organization.
2. In the **Medical Record Number** field, enter the medical record number within the provider's organization.

BILL INFORMATION	
<b>BILL DATA</b>	
Patient Account No.:	<input type="text"/>
Medical Record Number:	<input type="text"/>
Type Of Facility:	<input type="text"/> *
Bill Frequency:	<input type="text"/> *
Bill Classification:	<input type="text"/> *
Statement Dates: From:	MM DD CCYY* <input type="text"/> * <input type="text"/> * <input type="text"/> *
Admission Date/Hour:	MM DD CCYY HH MM <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> : <input type="text"/>
Admission Type:	<input type="text"/>
Admission Source:	<input type="text"/> *
Discharge Hour:	HH MM <input type="text"/> : <input type="text"/>
To:	MM DD CCYY* <input type="text"/> * <input type="text"/> * <input type="text"/> *

# Bill Information – Institutional (2 of 12)

3. Select the type of facility (the first digit for the type of bill) from the **Type Of Facility** drop-down list.
4. Select the bill frequency (the third digit for the type of bill) from the **Bill Frequency** drop-down list.
5. Select the bill classification (the second digit for the type of bill) from the **Bill Classification** drop-down list.

## Type of Facility Options

1-Hospital
2-Skilled Nursing
3-Home Health +
4-Religious Non-Medical Health Care Institutions - Hospital Inpatient (formerly referred to as Christi
5-Religious Non-Medical Health Care Institutions - Post-Hospital Extended Care Services (formerly refe
6-Intermediate Care
7-Clinic
8-Special Facility

BILL INFORMATION	
<b>BILL DATA</b>	
Patient Account No.:	<input type="text"/>
Medical Record Number:	<input type="text"/>
Type Of Facility:	<input type="text"/> *
Bill Frequency:	<input type="text"/> *
Bill Classification:	<input type="text"/> *
Statement Dates: From:	MM DD CCYY
To:	MM DD CCYY
Admission Date/Hour:	MM DD CCYY HH MM
Admission Type:	<input type="text"/>
Admission Source:	<input type="text"/>
Discharge Hour:	HH MM

# Bill Information – Institutional (3 of 12)

6. Enter the statement date range (cover period) in the **Statement Dates From** and **To** fields.
7. Enter admission date and time (in hours and minutes) in the **Admission Date/Hour** fields.

BILL INFORMATION											
<b>BILL DATA</b>											
Patient Account No.:		<input type="text"/>									
Medical Record Number:		<input type="text"/>									
Type Of Facility:		<input type="text"/> *									
Bill Frequency:		<input type="text"/> *									
Bill Classification:		<input type="text"/> *									
Statement Dates: From:		MM	DD	CCYY				To:	MM	DD	CCYY
		<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="text"/>	<input type="text"/>
			*	*					*	*	*
Admission Date/Hour:		MM	DD	CCYY	HH	MM					
		<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	:	<input type="text"/>			
Admission Type:		<input type="text"/>									
Admission Source:		<input type="text"/> *									
Discharge Hour:		HH	MM								
		<input type="text"/>	:	<input type="text"/>							



# Bill Information – Institutional (4 of 12)

8. Select the admission type (required for Inpatient Stay only) from the **Admission Type** drop-down list.
9. Select the admission source from the **Admission Source** drop-down list.

BILL INFORMATION												
<b>BILL DATA</b>												
Patient Account No.:		<input type="text"/>										
Medical Record Number:		<input type="text"/>										
Type Of Facility:		<input type="text"/> *										
Bill Frequency:		<input type="text"/> *										
Bill Classification:		<input type="text"/> *										
Statement Dates: From:		MM	DD	CCYY	To:					MM	DD	CCYY
		<input type="text"/>	<input type="text"/>	<input type="text"/>						<input type="text"/>	<input type="text"/>	<input type="text"/>
Admission Date/Hour:		MM	DD	CCYY	HH	MM						
		<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	:	<input type="text"/>				
Admission Type:		<input type="text"/>										
Admission Source:		<input type="text"/>										
Discharge Hour:		HH	MM									
		<input type="text"/>	:	<input type="text"/>								

# Bill Information – Institutional (5 of 12)

10. Enter the discharge time (in hours and minutes) in the **Discharge Hour** fields.

BILL INFORMATION											
BILL DATA											
Patient Account No.:		<input type="text"/>									
Medical Record Number:		<input type="text"/>									
Type Of Facility:		<input type="text"/> *									
Bill Frequency:		<input type="text"/> *									
Bill Classification:		<input type="text"/> *									
Statement Dates: From:		MM	DD	CCYY							
		<input type="text"/>	<input type="text"/>	<input type="text"/>							
		*	*	*							
To:		MM	DD	CCYY							
		<input type="text"/>	<input type="text"/>	<input type="text"/>							
		*	*	*							
Admission Date/Hour:		MM	DD	CCYY	HH	MM					
		<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	:	<input type="text"/>			
Admission Type:		<input type="text"/>									
Admission Source:		<input type="text"/> *									
Discharge Hour:		HH	MM								
		<input type="text"/>	:	<input type="text"/>							

# Bill Information – Institutional (6 of 12)

11. Select the patient status from the **Patient Status** drop-down list.
12. When the bill is related to an auto accident, select the state where it occurred from the **Auto Accident State** drop-down list.

The screenshot shows a medical billing form. A red rectangular box highlights the top two fields: "Patient Status:" and "Auto Accident State:". Both fields are drop-down menus with a downward arrow icon and an asterisk indicating they are required. Below these fields is a section titled "DIAGNOSIS INFORMATION (Do not use decimals or spaces)". This section contains several fields: "Diagnosis Code Category:" (drop-down), "Principal Diagnosis Code:" (text input with an asterisk), "Admitting Diagnosis Code:" (text input), "Present On Admission:" (drop-down), "PPS/DRG:" (text input), and "Reason For Visit:" (three text inputs labeled 1, 2, and 3). At the bottom of the form, there are six expandable sections, each with a red plus icon and a title: "OTHER DIAGNOSIS INFORMATION", "CONDITION INFORMATION", "OCCURRENCE INFORMATION", "OCCURRENCE SPAN INFORMATION", "VALUE INFORMATION", and "DELAY REASON".

# Bill Information – Institutional (7 of 12)

13. Select the diagnosis code category (ICD-9 or ICD-10) based on the cover period from the **Diagnosis Code Category** drop-down list.
14. Enter the principal diagnosis code in the **Principal Diagnosis Code** field.
15. Select whether the principal diagnosis code was present at the time of admission from the **Present On Admission** drop-down list.

## Note:

- At least one Diagnosis Code is required
- Providers must list all ICD-9 or ICD-10 codes based on the date of service (DOS)
- Providers must list ICD Codes in sequential order, one through 12 (do not skip a number)
- ICD-9 Diagnosis Codes (applies if DOS is on or prior to September 30, 2015)
- ICD-10 Diagnosis Codes (applies if DOS is on or after October 1, 2015)

Patient Status: \*

Auto Accident State:

**DIAGNOSIS INFORMATION (Do not use decimals or spaces)**

Diagnosis Code Category: \*

Principal Diagnosis Code: \*

Present On Admission:

Admitting Diagnosis Code:

PPS/DRG:

Reason For Visit: 1:  2:  3:

☐ **OTHER DIAGNOSIS INFORMATION**

☐ **CONDITION INFORMATION**

☐ **OCCURRENCE INFORMATION**

☐ **OCCURRENCE SPAN INFORMATION**

☐ **VALUE INFORMATION**

☐ **DELAY REASON**

# Bill Information – Institutional (8 of 12)

16. Enter the admitting diagnosis code in the **Admitting Diagnosis Code** field.
17. Enter the reasons for the visit (diagnosis code describing the patient's stated reason for seeking care) in the **Reason For Visit** fields.

Patient Status:	<input type="text"/>	*
Auto Accident State:	<input type="text"/>	
<b>DIAGNOSIS INFORMATION (Do not use decimals or spaces)</b>		
Diagnosis Code Category:	<input type="text"/>	*
Principal Diagnosis Code:	<input type="text"/>	*
Present On Admission:	<input type="text"/>	
Admitting Diagnosis Code:	<input type="text"/>	PPS/DRG: <input type="text"/>
Reason For Visit:	1: <input type="text"/>	2: <input type="text"/> 3: <input type="text"/>
<b>+ OTHER DIAGNOSIS INFORMATION</b>		
<b>+ CONDITION INFORMATION</b>		
<b>+ OCCURRENCE INFORMATION</b>		
<b>+ OCCURRENCE SPAN INFORMATION</b>		
<b>+ VALUE INFORMATION</b>		
<b>+ DELAY REASON</b>		

# Bill Information – Institutional (9 of 12)

The following slides guide providers through completing the **Bill Information** section. The sub-headings that have a plus icon (+) next to them are expandable. When the provider selects the plus icon (+), the provider can enter information as needed in the expanded subsection. All expandable fields are optional until expanded. Once expanded, certain fields may become mandatory, indicated by an asterisk (\*). Fields collapse and return to the default optional state by selecting the minus icon (−).

When a subsection expands, fields with an asterisk (\*) are mandatory. To collapse a subsection without including any additional information, providers can select the minus icon (−).

The following fields default as optional until the provider expands them:

- OTHER DIAGNOSIS INFORMATION
- CONDITION INFORMATION
- OCCURRENCE INFORMATION
- OCCURRENCE SPAN INFORMATION
- VALUE INFORMATION
- DELAY REASON

Patient Status: \*

Auto Accident State:

**DIAGNOSIS INFORMATION (Do not use decimals or spaces)**

Diagnosis Code Category:  ICD-10-CM\*

Principal Diagnosis Code: \*

Admitting Diagnosis Code:

Reason For Visit: 1:  2:  3:

Present On Admission:

PPS/DRG:

**OTHER DIAGNOSIS INFORMATION**

**CONDITION INFORMATION**

**OCCURRENCE INFORMATION**

**OCCURRENCE SPAN INFORMATION**

**VALUE INFORMATION**

**DELAY REASON**

# Bill Information – Institutional (10 of 12)

In this section, the provider may enter additional bill information pertaining to the service provided to the claimant.

18. If applicable, complete the following:

- **OTHER DIAGNOSIS INFORMATION**
- **CONDITION INFORMATION**
- **OCCURRENCE INFORMATION**
- **OCCURRENCE SPAN INFORMATION**
- **VALUE INFORMATION**
- **DELAY REASON**

**Note:** To enter additional information, providers can select the **Add Another** link.

<b>OTHER DIAGNOSIS INFORMATION</b>						
1 Other Diagnosis Code:	<input type="text"/>	Present On Admission:	<input type="text"/>	<a href="#">Add Another</a>		
<b>CONDITION INFORMATION</b>						
1 Condition Code:	<input type="text"/>	<a href="#">Add Another</a>				
<b>OCCURRENCE INFORMATION</b>						
1 Occurrence Code:	<input type="text"/>	Occurrence Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy	<a href="#">Add Another</a>		
<b>OCCURRENCE SPAN INFORMATION</b>						
1 Occurrence Span Code	<input type="text"/>	From Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy	Through Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy	<a href="#">Add Another</a>
<b>VALUE INFORMATION</b>						
1 Value Code:	<input type="text"/>	Value Amount:	\$	<input type="text"/>	<a href="#">Add Another</a>	
<b>DELAY REASON</b>						
Delay Reason Code:	<input type="text"/>					

# Bill Information – Institutional (11 of 12)

19. Enter the prior authorization number to be applied to this bill in the **Prior Authorization Number** field. (Optional)

**PRIOR AUTHORIZATION**

Prior Authorization Number:

☐

**PROCEDURE INFORMATION**

☐

**OPERATING PHYSICIAN INFORMATION**

☐

**OTHER OPERATING PHYSICIAN INFORMATION**

☐

**RENDERING PHYSICIAN INFORMATION**

☐

**REFERRING PHYSICIAN INFORMATION**

☐

**BILL NOTE**



# Bill Information – Institutional (12 of 12)

**Note:** Providers can select the plus icon (+) to add Procedure Information, Other Procedure Information, Operating Physician Information, Other Operating Physician Information, Rendering Physician Information, Referring Physician Information, and a Bill Note. Providers can select the minus icon (–) to minimize a section if no longer needed.

The screenshot displays a form titled "Bill Information – Institutional (12 of 12)". The form contains several expandable sections, each with a plus icon (+) in a red box on the left. The sections are:

- PROCEDURE INFORMATION**: Includes fields for "Principal Procedure Code:" and "Procedure Date:" (with mm, dd, ccyy sub-fields).
- Other Procedure Information**: Includes a field for "1 Other Procedure Code:" and "Procedure Date:" (with mm, dd, ccyy sub-fields). A blue link "Add Another" is visible.
- OPERATING PHYSICIAN INFORMATION**: Includes fields for "Provider ID:" and "Type:" (with a dropdown menu).
- OTHER OPERATING PHYSICIAN INFORMATION**: Includes fields for "Provider ID:" and "Type:" (with a dropdown menu).
- RENDERING PHYSICIAN INFORMATION**: Includes fields for "Provider ID:" and "Type:" (with a dropdown menu).
- REFERRING PHYSICIAN INFORMATION**: Includes fields for "Provider ID:" and "Type:" (with a dropdown menu).
- BILL NOTE**: Includes a large text area for "Bill Note:" and a "Characters Remaining:" indicator showing 80.

# Service Line Item Information – Institutional (1 of 7)

**Enter the following Service Line Item information:**

1. Complete the **Revenue Code** field.
2. Enter the CPT or HCPCS Code in the **HCPCS Code** field.

**Note:** Not all revenue codes require a CPT or HCPCS Code.

SERVICE LINE ITEM INFORMATION				
<b>Service Line Items</b>				
Revenue Code:	<input type="text"/>		*	
HCPCS Code:	<input type="text"/>		Modifiers: 1: <input type="text"/> 2: <input type="text"/> 3: <input type="text"/> 4: <input type="text"/>	
Service Date:	MM	DD	CCYY	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Last Date of Service:	MM	DD	CCYY	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Service Units:	<input type="text"/>		*	
Total Line Charges:	<input type="text"/>		*	
Third Party Liability Amount:	<input type="text"/>		Non-covered Line Charges: <input type="text"/>	

# Service Line Item Information – Institutional (2 of 7)

3. Enter modifiers in the **Modifiers** fields. (Optional)
4. Complete the **Service Date** and **Last Date of Service** fields for the line item.

SERVICE LINE ITEM INFORMATION				
<b>Service Line Items</b>				
Revenue Code:	<input type="text"/>			
HCPCS Code:	<input type="text"/>		Modifiers: 1: <input type="text"/> 2: <input type="text"/> 3: <input type="text"/> 4: <input type="text"/>	
Service Date:	MM	DD	CCYY	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Last Date of Service:	MM	DD	CCYY	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Service Units:	<input type="text"/>			
Total Line Charges:	<input type="text"/>		Non-covered Line Charges: <input type="text"/>	
Third Party Liability Amount:	<input type="text"/>			

# Service Line Item Information – Institutional (3 of 7)

5. Complete the **Service Units** fields.
6. Complete the **Total Line Charges** fields.

SERVICE LINE ITEM INFORMATION				
<b>Service Line Items</b>				
Revenue Code:	<input type="text"/> *			
HCPCS Code:	<input type="text"/>	Modifiers: 1: <input type="text"/> 2: <input type="text"/> 3: <input type="text"/> 4: <input type="text"/>		
Service Date:	MM	DD	CCYY	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Last Date of Service:	MM	DD	CCYY	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Service Units:	<input type="text"/> *			
Total Line Charges:	<input type="text"/> *			
Third Party Liability Amount:	<input type="text"/>			
	Non-covered Line Charges: <input type="text"/>			

# Service Line Item Information – Institutional (4 of 7)

7. Complete the **Third Party Liability Amount** field. (Optional)
8. Complete the **Non-covered Line Charges** field. (Optional)

SERVICE LINE ITEM INFORMATION				
<b>Service Line Items</b>				
Revenue Code:	<input type="text"/>		*	
HCPSC Code:	<input type="text"/>		Modifiers:	1: <input type="text"/> 2: <input type="text"/> 3: <input type="text"/> 4: <input type="text"/>
Service Date:	MM	DD	CCYY	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Last Date of Service:	MM	DD	CCYY	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Service Units:	<input type="text"/>		*	
Total Line Charges:	<input type="text"/>		*	
Third Party Liability Amount:	<input type="text"/>			
			Non-covered Line Charges:	<input type="text"/>

# Service Line Item Information – Institutional (5 of 7)

9. Complete the following fields as applicable:


- If the operating physician, other operating physician, rendering physician, or referring physician is the same as the header provider information, then leave blank.
- If the operating physician, other operating physician, rendering physician, or referring physician differ from the header provider information input during the **Provider Information** section, enter the National Provider ID (NPI) in the **Operating Physician ID**, **Other Operating Physician ID**, **Rendering Physician ID**, or **Referring Physician ID** field and select **NPI** from the **Type** drop-down list.

**Note:** If a rendering physician NPI is submitted, providers are encouraged to also enter the appropriate taxonomy code.

Operating Physician ID (If different from header):	<input type="text"/>	Type:	<input type="text" value="v"/>
Other Operating Physician ID (If different from header):	<input type="text"/>	Type:	<input type="text" value="v"/>
Rendering Physician ID (If different from header):	<input type="text"/>	Type:	<input type="text" value="v"/>
Referring Physician ID (If different from header):	<input type="text"/>	Type:	<input type="text" value="v"/>

 **LINE DRUG INFORMATION**

**Note:** Providers can select the plus icon (+) to add **LINE DRUG INFORMATION** or the minus icon (–) to minimize it if it is no longer needed.

 **LINE DRUG INFORMATION**

National Drug Code:	<input type="text" value="*"/>	Quantity:	<input type="text" value="*"/>	Unit:	<input type="text" value="v"/>	Qualifier:	<input type="text" value="v"/>
Prescription/Link No:	<input type="text"/>						

# Service Line Item Information – Institutional (6 of 7)

10. To add a line item to the bill, select **Add Service Line Item**. Repeat this process for each additional line. A window displays to confirm the Service Line is added successfully.
11. Select **OK** to close the window.

**Note:** Providers can select **Update Service Line Item** to update a line item that was previously added.

Add Service Line Item

Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: \$ 200.00

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non-covered Charges	
			1	2	3	4	Service Date	Last DOS				
<a href="#">1</a>	0320						02/20/2020	02/20/2020	2	\$ 200.00		<a href="#">Delete</a>

Once a line item has been added, the line item information displays.

12. Proceed with the line item information as follows:
  - To update the line item information, select the **Line No** link.
  - To remove the line item, select the **Delete** link.

Add Service Line Item

Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

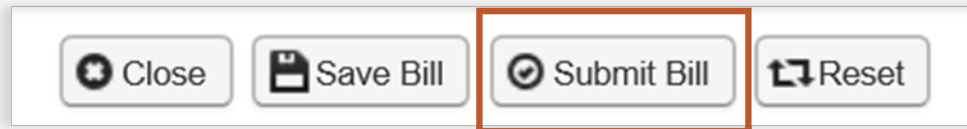
Total Submitted Charges: \$ 200.00

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non-covered Charges	
			1	2	3	4	Service Date	Last DOS				
<a href="#">1</a>	0320						02/20/2020	02/20/2020	2	\$ 200.00		<a href="#">Delete</a>

# Service Line Item Information – Institutional (7 of 7)

13. Once the provider enters all line items, scroll back to the top of the page and select **Submit Bill** to submit the bill.

**Note:** The provider also has the option to save the bill and return later or reset the bill to start over. To view the steps on retrieving a saved bill, proceed to the [Retrieving Saved Bills](#) section of this document.



**Note:** Saved Bills will be available under the **Retrieve Saved Bills** menu for a later submission.

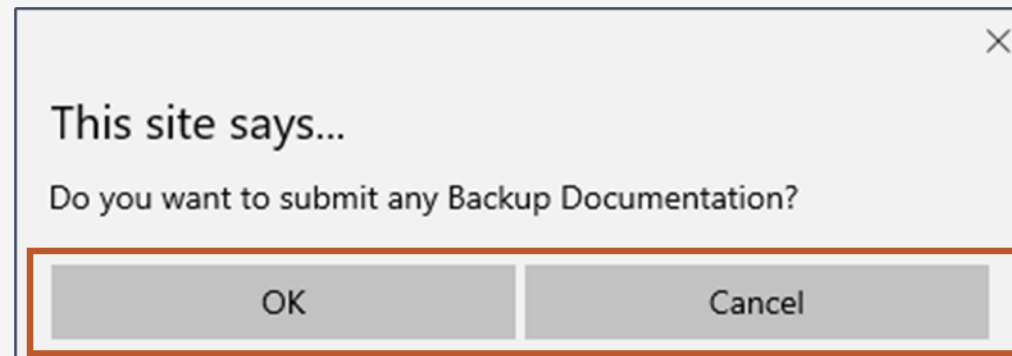


# Adding an Attachment – Institutional (1 of 3)

After selecting **OK** to proceed to add or updated the line, a popup window opens with the message "Do you want to submit any Backup Documentation?"

1. Proceed as applicable:

- To add attachments, select **OK**. The **Add Attachments** window opens.
- To proceed without attachments (no attachment is needed), select **Cancel**.



# Adding an Attachment – Institutional (2 of 3)

2. In the **Add Attachments** window, select the **Attachment Type** being submitted for the services rendered and select the **Transmission Code**.

**Note:** Attachments can only be attached if selecting Transmission Code of **EL** or **FT**.

Please select one of the option from the Required Fields \* and select Line No, if the attachment is for specific Service Line Item.

Attachment Type: 03-03-Report Justifying Treatment f \* Transmission Code: EL-Electronically Only \*  
Line No: (Do not select Line No to attach a document at header level)

Please attach the File(s). The File Format must be PDF,TIF,TIFF

Upload File \*

Please be sure the supporting documentation/attachments is for the treated claimant ONLY.  
Please do not upload supporting documentation/attachments for any other claimant as this could potentially cause a denial of your bill or an unintended disclosure of protected health information (PHI).

OK Cancel

AA-Available on Request at Provid  
BM-By Mail  
EL-Electronically Only  
EM-E-Mail  
FT-FT-File Transfer  
FX-By-Fax

3. To locate and add the attachment, select **Upload File**, then select **OK**.

Please select one of the option from the Required Fields \* and select Line No, if the attachment is for specific Service Line Item.

Attachment Type: 03-03-Report Justifying Treatment f \* Transmission Code: EL-Electronically Only \*  
Line No: (Do not select Line No to attach a document at header level)

Please attach the File(s). The File Format must be PDF,TIF,TIFF

Upload File \*

Please be sure the supporting documentation/attachments is for the treated claimant ONLY.  
Please do not upload supporting documentation/attachments for any other claimant as this could potentially cause a denial of your bill or an unintended disclosure of protected health information (PHI).

OK Cancel

# Adding an Attachment – Institutional(3 of 3)

Once the **Submit Bill** tab is selected, the Transaction Control Number (TCN) displays and the option to add additional attachments displays. Once the attachment is added, it will be listed in the **Attachment List** section.

4. To complete the physician or supplier attestation, select the **SIGNATURE OF PHYSICIAN OR SUPPLIER** checkbox.

Submitted Institutional Bill Details

The 'Submit' button must be clicked to send the Bill for processing. If not, the Bill will be available under 'Retrieve Saved Bills' menu for later submission.

Transaction Control Number (TCN): [REDACTED]  
Provider ID: [REDACTED]  
Claimant ID: [REDACTED]  
Date of Service: 10/31/2023-10/31/2024  
Total Bill Charges: \$ 600.00

☐ **SIGNATURE OF PHYSICIAN OR SUPPLIER**

Checking this box 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). Checking this box 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, BLBA 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 acknowledgement indicates that you understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Please click "Add Attachment" button, to attach the documents.

Add Attachment

Attachment List

<input type="checkbox"/>	Line No ▲▼	File Name ▲▼	Attachment Type ▲▼	Transmission Code ▲▼	Attachment Control # ▲▼	File Size ▲▼	Delete ▲▼	Uploaded On ▲▼
<input type="checkbox"/>	1	Supporting Document.pdf	03	EL	201446514	27kb	X	05/07/2025

View Page: 1 Go Page Count

Viewing Page: 1

SaveToCSV

Print Print Cover Page Submit

# Submitted Institutional Bill Details

5. To submit the bill, select **Submit**. Once submitted, the “Do you want to Submit another Bill?” confirmation alert message displays.



**Important:** For transmission codes of AA, BM, EM, and FX, the provider will need to select **Print Cover Page** to mail or fax the attachments. Refer to [How to View PDFs Using Adobe Reader](#) for instructions on how to view PDFs using Adobe Reader.

Submitted Institutional Bill Details

The 'Submit' button must be clicked to send the Bill for processing. If not, the Bill will be available under 'Retrieve Saved Bills' menu for later submission.

Transaction Control Number (TCN):   
Provider ID:   
Claimant ID:   
Date of Service: 10/31/2023-10/31/2024  
Total Bill Charges: \$ 600.00

☐ **SIGNATURE OF PHYSICIAN OR SUPPLIER**

Checking this box 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). Checking this box 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, BLBA 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 acknowledgement indicates that you understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Please click "Add Attachment" button, to attach the documents.

Add Attachment

Attachment List

<input type="checkbox"/>	Line No ▲▼	File Name ▲▼	Attachment Type ▲▼	Transmission Code ▲▼	Attachment Control # ▲▼	File Size ▲▼	Delete ▲▼	Uploaded On ▲▼
<input type="checkbox"/>	1	Supporting Document.pdf	03	EL	201446514	27kb	X	05/07/2025

View Page: 1 Go Page Count

Viewing Page: 1

« First < Prev > Next » Last

SaveToCSV

Print Print Cover Page Submit

# Missing Data Message – Institutional

Most billing providers are required to include the Billing NPI. For OWCP bills submitted from providers such as non-medical vendors, fiscal intermediaries, and non-emergency transportation, Billing NPI is not required.

- If the **NPI** is missing, an error message will display.

The following is required information that the provider may be prompted to enter:

- Billing Provider Information – NPI
- If the **Taxonomy Code** is missing or invalid, a warning message will display.
  - Providers are encouraged to submit taxonomy details for Billing Provider and NPI or taxonomy details for Rendering Provider at header and lines.
  - Review the following missing NPI or taxonomy information:
    - Billing Provider Information - Taxonomy Code
    - Attending Provider - Taxonomy Code

**Note:** The provider can select **Cancel** to return to the bill and enter the details or they can select **OK** to proceed with submission.

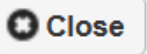
## Submitting a **Dental Bill** in the WCMBP System



# Submitting a Dental Bill in the WCMBP System

1. To begin entering a Dental claim using Direct Data Entry (DDE), select the **Submit Dental** link.



**Note:** PROVIDER INFORMATION — To access and view the **Bill Submission** page after submitting a bill, providers must disable their popup blocker.







Choose an Option.	
<a href="#">Submit Professional</a> (OWCP-1500)	Submit Professional Use this option for services rendered by providers enrolled as Individual, Group or Ambulatory Surgical Centers.
<a href="#">Submit Institutional</a> (OWCP-04)	Submit Institutional Use this option for services rendered by providers enrolled as a facility.
<a href="#">Submit Dental</a>	Submit Dental





# Program – Dental



2. Select the claimant program for the bill being submitted from the **Program** drop-down list.

  Profile: EXT Provider Bills Submitter ▾

 External Links  Help  Logout

 > [Provider Portal](#) > [Bill Submission](#) > [Dental Bill](#)

 Close  Save Bill  Submit Bill  Reset

 **Dental Bill** 

Note: asterisks ( \* ) denote required fields.

**Basic Bill Info**

Provider | Claimant | Bill | Service

Program:

Special Bill Indicator:

Submitter ID:



# Provider Information – Dental(1 of 4)

1. Enter the Billing Provider National Provider ID (NPI) number in the **NPI** field.

**Note:** BILLING PROVIDER INFORMATION—such as Provider ID, Type, Provider Name, and Address—will display based on the provider profile of the user logged in. The provider is required to enter the National Provider ID (NPI) and is strongly encouraged to enter the billing Taxonomy Code in the designated field.

**PROVIDER INFORMATION**

**BILLING PROVIDER INFORMATION**

Provider ID:  Type:  Taxonomy Code:

NPI:

Provider Name:

Address Line 1:  \* Address Line 2:

Address Line 3:

City/Town:  \*  
State/Province:  \*  
County:  \*  
Country:  \*  
Zip Code:  -

2. To make changes to the Billing Provider address, select **+Address**. The **Address details** window opens.
  - a. Enter the address and zip code in the **Address Line 1** and **Zip Code** fields.
  - b. Select **Validate Address**. The remaining address fields automatically populate.
  - c. To return to the **Professional Bills Online Submission** page, select **OK**.

**Address details**

Address Line 1:  \* Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

City/Town:  \*  
State/Province:  \*  
County:  \*  
Country:  \*  
Zip Code:  -

# Provider Information – Dental (2 of 4)

The **Is the Billing Provider also the Rendering Provider** section automatically defaults to **No**.

3. Complete the **Is the Billing Provider also the Rendering Provider** section as applicable:

- If yes (the Billing Provider is also the Rendering Provider), select **Yes**. The **RENDERING PROVIDER INFORMATION** section collapses.
- If no (the Billing Provider differs from the Rendering Provider), complete the following:
  - a. Enter the Rendering Provider NPI in the **Provider ID** field.
  - b. Select the NPI from the **Type** drop-down list.

**Note:** Providers are encouraged to enter the **Taxonomy Code**.

<b>?</b> Is the Billing Provider also the Rendering Provider? <input type="radio"/> Yes <input checked="" type="radio"/> No		
<b>RENDERING PROVIDER INFORMATION</b>		
Provider ID: <input type="text"/> *	Type: <input type="text"/> *	Taxonomy Code: <input type="text"/>
<b>?</b> Is the Billing Provider also the Supervising Provider? <input type="radio"/> Yes <input checked="" type="radio"/> No		
<b>SUPERVISING PROVIDER INFORMATION</b>		
Provider ID: <input type="text"/> *	Type: <input type="text"/> *	
<b>?</b> Is this service the result of a referral? <input checked="" type="radio"/> Yes <input type="radio"/> No		
<b>REFERRING PROVIDER INFORMATION</b>		
Provider ID: <input type="text"/> *	Type: <input type="text"/> *	Taxonomy Code: <input type="text"/>

# Provider Information – Dental (3 of 4)

The **Is the Billing Provider also the Supervising Provider?** section automatically defaults to **Yes**.

4. Complete the **Is the Billing Provider also the Supervising Provider?** section.
  - If yes (the Billing Provider is also the Supervising Provider), proceed to the next step.
  - If no (the Billing Provider differs from the Supervising Provider), select **No**. The **SUPERVISING PROVIDER INFORMATION** section expands.
    - a. Enter the supervising provider's NPI in the **Provider ID** field.
    - b. Select **NPI** from the **Type** drop-down list.

<b>?</b> Is the Billing Provider also the Rendering Provider? <input type="radio"/> Yes <input checked="" type="radio"/> No		
<b>RENDERING PROVIDER INFORMATION</b>		
Provider ID: <input type="text"/> *	Type: <input type="text"/> *	Taxonomy Code: <input type="text"/>
<b>?</b> Is the Billing Provider also the Supervising Provider? <input type="radio"/> Yes <input checked="" type="radio"/> No		
<b>SUPERVISING PROVIDER INFORMATION</b>		
Provider ID: <input type="text"/> *	Type: <input type="text"/> *	
<b>?</b> Is this service the result of a referral? <input checked="" type="radio"/> Yes <input type="radio"/> No		
<b>REFERRING PROVIDER INFORMATION</b>		
Provider ID: <input type="text"/> *	Type: <input type="text"/> *	Taxonomy Code: <input type="text"/>

# Provider Information – Dental(4 of 4)

The **Is the Service the result of a referral?** section automatically defaults to **No**.

5. Complete the **Is the Service the result of a referral?** section.

- If no (the service is not a result of a referral), proceed to the next step.
- If yes (the service is a result of a referral), select **Yes**. The **REFERRING PROVIDER INFORMATION** section expands.
  - a. Enter the referring provider's NPI in the **Provider ID** field.
  - b. Select **NPI** from the **Type** drop-down list.

**Note** : Providers are encouraged to enter **Taxonomy**.

<input checked="" type="radio"/> Yes <input type="radio"/> No		
<b>RENDERING PROVIDER INFORMATION</b>		
Provider ID: <input type="text"/>	Type: <input type="text"/>	Taxonomy Code: <input type="text"/>
<input checked="" type="radio"/> Yes <input type="radio"/> No		
<b>SUPERVISING PROVIDER INFORMATION</b>		
Provider ID: <input type="text"/>	Type: <input type="text"/>	
<input checked="" type="radio"/> Yes <input type="radio"/> No		
<b>REFERRING PROVIDER INFORMATION</b>		
Provider ID: <input type="text"/>	Type: <input type="text"/>	Taxonomy Code: <input type="text"/>

# Claimant Information – Dental

1. Enter the **Claimant ID**.
2. Select the case number from the **Type** drop-down list.

**Note:** FECA, DCMWC, and DEEOIC can enter a social security number (SSN) or Case Number. If an SSN is entered for a FECA claimant, the **Date of Injury** field is required.

**Note:** If claimant information is found based on Type (Case Number or SSN), the system will auto-populate the claimant's information. If the system cannot locate claimant information, the system will display a message stating, "CLAIMANT INFORMATION—Claimant details not found for the program selected". Providers will need to manually enter the claimant information.

The screenshot shows a web form titled "CLAIMANT INFORMATION". It contains several input fields: "Claimant ID:" (a text box), "Type:" (a drop-down menu), "Date of Injury:" (MM, DD, CCYY fields with a note "(Required when SSN is keyed in to submit bill for DFEC Claimant)"), "Last Name:" (text box), "First Name:" (text box), "Middle Name:" (text box), "Suffix:" (text box), "Date of Birth:" (MM, DD, CCYY fields), "State/Province:" (drop-down menu), and "Zip Code:" (text box). The "Claimant ID" and "Type" fields are highlighted with red boxes.

The **Does Bill have any Third-Party Liability Amount?** section automatically defaults to **No**.

3. Complete the **Does Bill have any Third-Party Liability Amount?** section as applicable:
  - If no (the bill does not include Third-Party Liability (TPL) amount), proceed to the next step.
  - If yes (there is a TPL amount to be listed), select **Yes** and enter the amount that was paid by a Third-Party Liability (TPL) in the **Third Party Liability Amount** field.

The screenshot shows a section titled "Does Bill have any Third Party Liability Amount?" with a question mark icon and radio buttons for "Yes" and "No". Below this is a sub-section titled "Third Party Liability Information" with a text box labeled "Third Party Liability Amount:".

# Bill Information – Dental (1 of 7)

Enter the following bill information:

1. In the **Patient Account No.** field, enter the patient's account number within the provider's organization.

BILL INFORMATION

BILL DATA

Patient Account No:

Place of Service:

Service Start Date:

Service End Date:

PRIOR AUTHORIZATION

Prior Authorization Number:

DELAY REASON

Delay Reason Code:




BILL NOTE

Bill Note:

Characters Remaining: 500

# Bill Information – Dental (2 of 7)

2. Select the place of service from the **Place of Service** drop-down list.

 <b>BILL INFORMATION</b>					
<b>BILL DATA</b>					
Patient Account No:		<input type="text"/>			
Place of Service:		<input type="text" value="v"/> *			
		mm	dd	ccyy	
Service Start Date:		<input type="text"/>	<input type="text"/>	<input type="text"/>	*
Service End Date:		<input type="text"/>	<input type="text"/>	<input type="text"/>	*
<b>PRIOR AUTHORIZATION</b>					
Prior Authorization Number:		<input type="text"/>			
 <b>DELAY REASON</b>					
Delay Reason Code:		<input type="text" value="v"/> *			
 <b>BILL NOTE</b>					
Bill Note:		<input type="text"/>			
Characters Remaining:		80			

# Bill Information – Dental(3 of 7)

- Enter the date of service range in the **Service Start Date** and **Service End Date** fields.

BILL INFORMATION					
BILL DATA					
Patient Account No:	<input type="text"/>				
Place of Service:	<input type="text"/> *				
Service Start Date:	mm	dd	ccyy	Service End Date:	mm dd ccyy
<input type="text"/>	<input type="text"/>	<input type="text"/>	*	<input type="text"/>	<input type="text"/>
PRIOR AUTHORIZATION					
Prior Authorization Number:	<input type="text"/>				
DELAY REASON					
Delay Reason Code:	<input type="text"/> *				
BILL NOTE					
Bill Note:	<input type="text"/>				
Characters Remaining:	80				



# Bill Information – Dental(4 of 7)

The following slides guide providers through completing the **Bill Information** section. The sub-headings that have a plus icon (+) next to them are expandable. When the provider selects the plus icon (+), the provider can enter information as needed in the expanded subsection.

When a subsection expands, fields with an asterisk (\*) are mandatory. To collapse a subsection without including any additional information, select the minus icon (–).

The following fields default as optional until the provider expands them:

- DELAY REASON
- BILL NOTE

The screenshot displays the 'BILL INFORMATION' form. It features a 'BILL DATA' section with fields for Patient Account No., Place of Service (dropdown), Service Start Date (mm/dd/ccyy), and Service End Date (mm/dd/ccyy). Below this is a 'PRIOR AUTHORIZATION' section, which is highlighted with a red box. This section includes a 'Prior Authorization Number' field, a 'DELAY REASON' subsection (indicated by a plus icon), a 'Delay Reason Code' dropdown, and a 'BILL NOTE' subsection (indicated by a plus icon) with a 'Bill Note' text area. At the bottom, a 'Characters Remaining' indicator shows 80 characters left.

BILL INFORMATION	
<b>BILL DATA</b>	
Patient Account No:	<input type="text"/>
Place of Service:	<input type="text" value="v"/>
Service Start Date:	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>
Service End Date:	<input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>
<b>PRIOR AUTHORIZATION</b>	
Prior Authorization Number:	<input type="text"/>
<b>DELAY REASON</b>	
Delay Reason Code:	<input type="text" value="v"/>
<b>BILL NOTE</b>	
Bill Note:	<input type="text"/>
Characters Remaining:	80

# Bill Information – Dental (5 of 7)

The **Is this bill accident related?** section automatically defaults to **No**.

4. Complete the **Is the bill accident related?** section as applicable:

- If no (the bill is not accident related), proceed to the next step.
- If yes (the bill is accident related), select **Yes**. The **Related Causes Information** section expands.
  - a. Select the related cause or causes from the **Related Causes** drop-down list.
  - b. Enter the accident date in the **Accident Date** field.

?

Is this bill accident related?

Yes

No

RELATED CAUSES INFORMATION

Related Causes: 1.  \* 2.  \*

Auto Accident State:  Accident Country: US Accident Date: 

MM

DD

CCYY

 \*

?

Is this bill related to orthodontic services?

Yes

No

ORTHODONTIC TREATMENT

Orthodontics Treatment Months:

Orthodontics Treatment Months Remaining:

Appliance Placement Date: 

MM

DD

CCYY

TOOTH STATUS

1 Tooth Number:  Tooth Status Code: 

Add Another:

?

Does this bill require a diagnosis code?

Yes

No

Diagnosis Codes (Do not use decimals or spaces)

Diagnosis Code Category:  \*

Diagnosis Codes: 1:  \* 2:  3:  4:

# Bill Information – Dental(6 of 7)

The **Is this bill related to orthodontic services?** section automatically defaults to **No**.

5. Complete the **Is this bill related to orthodontic services?** section as applicable:

- If no (the bill is not orthodontic related), proceed to the next step.
- If yes (the bill is orthodontic related), select **Yes**. The **ORTHODONTIC TREATMENT** section expands.
  - a. Enter the orthodontic treatment information
  - b. To expand the **TOOTH STATUS** section, select the plus icon (+).

**?** Is this bill accident related? ☒ Yes ☐ No

**RELATED CAUSES INFORMATION**

Related Causes: 1.  \* 2.  \*

Auto Accident State:  Accident Country: US Accident Date:  MM  DD  CCYY \*

**?** Is this bill related to orthodontic services? ☒ Yes ☐ No

**ORTHODONTIC TREATMENT**

Orthodontics Treatment Months:

Orthodontics Treatment Months Remaining:

MM DD CCYY

Appliance Placement Date:

**+** **TOOTH STATUS**

1 Tooth Number:  Tooth Status Code:  Add Another: [Add Another](#)

**?** Does this bill require a diagnosis code? ☒ Yes ☐ No

**Diagnosis Codes (Do not use decimals or spaces)**

Diagnosis Code Category:  \*

Diagnosis Codes: 1:  \* 2:  3:  4:

# Bill Information – Dental (7 of 7)

The **Does this bill require a diagnosis code** section automatically defaults to **No**.

6. Complete the **Does the bill require a diagnosis code** section as applicable:

- If no (the bill does not require a diagnosis code), proceed to the next step.
- If yes (the bill requires a diagnosis code), select **Yes**. The section expands.
  - a. Select the diagnosis code from the **Diagnosis Code Category** drop-down list.
  - b. Enter the diagnosis code or codes in the **Diagnosis Codes** fields.

?

Is this bill accident related?

☒ Yes ☐ No

RELATED CAUSES INFORMATION

Related Causes: 1.  \* 2.

Auto Accident State:  Accident Country: US Accident Date: 

MM

DD

CCYY

 \*

?

Is this bill related to orthodontic services?

☒ Yes ☐ No

ORTHODONTIC TREATMENT

Orthodontics Treatment Months:

Orthodontics Treatment Months Remaining:

MM DD CCYY

Appliance Placement Date:

TOOTH STATUS

1 Tooth Number:  Tooth Status Code: [Add Another:](#)

?

Does this bill require a diagnosis code?

☒ Yes ☐ No

Diagnosis Codes (Do not use decimals or spaces)

Diagnosis Code Category:  \*

Diagnosis Codes: 1:  \* 2:  3:  4:

# Basic Line Item Information – Dental (1 of 11)

## Enter the following Basic Line Item information:

1. Enter the date of service in the **Service Date** fields.
2. Enter the appliance placement date in the **Appliance Placement Date** fields.

BASIC LINE ITEM INFORMATION									
<b>BASIC SERVICE LINE ITEMS</b>									
Service Date:	MM	DD	CCYY	Appliance Placement Date:	MM	DD	CCYY		
	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>		
Place of Service (If different from header):	<input type="text"/>								
Oral Cavity Designation: 1:	<input type="text"/>	2:	<input type="text"/>	3:	<input type="text"/>	4:	<input type="text"/>	5:	<input type="text"/>
Fees:	<input type="text"/>								
Procedure Code:	<input type="text"/>			Quantity:	<input type="text"/>				
Third Party Liability Amount:	<input type="text"/>								
Diagnosis Pointers: 1:	<input type="text"/>	2:	<input type="text"/>	3:	<input type="text"/>	4:	<input type="text"/>		
Prior Authorization Number:	<input type="text"/>								
Rendering Provider ID (If different from header):	<input type="text"/>			Type:	<input type="text"/>			Taxonomy Code:	<input type="text"/>
Supervising Provider ID (If different from header):	<input type="text"/>			Type:	<input type="text"/>				

## Basic Line Item Information – Dental (2 of 11)

3. Select a place of service from the **Place of Service (if different from header)** drop-down list.
- 
- The screenshot shows the 'BASIC LINE ITEM INFORMATION' form. The 'Place of Service (if different from header)' dropdown is highlighted with a red box. The form includes the following fields:
- Service Date:** MM DD CCYY (MM, DD, CCYY are separate input boxes)
  - Appliance Placement Date:** MM DD CCYY (MM, DD, CCYY are separate input boxes)
  - Place of Service (if different from header):** (Dropdown menu, highlighted with a red box)
  - Oral Cavity Designation:** 1: [Dropdown] 2: [Dropdown] 3: [Dropdown] 4: [Dropdown] 5: [Dropdown]
  - Fees:** [Input box] \*
  - Procedure Code:** [Input box] \*
  - Third Party Liability Amount:** [Input box]
  - Diagnosis Pointers:** 1: [Dropdown] 2: [Dropdown] 3: [Dropdown] 4: [Dropdown]
  - Prior Authorization Number:** [Input box]
  - Rendering Provider ID (if different from header):** [Input box]
  - Supervising Provider ID (if different from header):** [Input box]
  - Quantity:** [Input box] \*
  - Type:** [Dropdown menu]
  - Taxonomy Code:** [Input box]

# Basic Line Item Information – Dental (3 of 11)

4. Select the oral cavity designation from the **Oral Cavity Designation** drop-down lists.

BASIC LINE ITEM INFORMATION

BASIC SERVICE LINE ITEMS

Service Date:MMDDCCYY

Appliance Placement Date:MMDDCCYY

Place of Service (If different from header):

Oral Cavity Designation: 1:2:3:4:5:

Fees:

Procedure Code:Quantity:

Third Party Liability Amount:

Diagnosis Pointers: 1:2:3:4:

Prior Authorization Number:

Rendering Provider ID (If different from header):Type:

Supervising Provider ID (If different from header):Type:

Taxonomy Code:

Tooth Information

# Basic Line Item Information – Dental (4 of 11)

5. Enter submitted charges for the line item in the **Fees** field.



BASIC LINE ITEM INFORMATION									
BASIC SERVICE LINE ITEMS									
Service Date:	MM	DD	CCYY	Appliance Placement Date:	MM	DD	CCYY		
	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>		
Place of Service (If different from header):	<input type="text"/>								
Oral Cavity Designation: 1:	<input type="text"/>	2:	<input type="text"/>	3:	<input type="text"/>	4:	<input type="text"/>	5:	<input type="text"/>
Fees:	<input type="text"/>								
Procedure Code:	<input type="text"/>			Quantity:	<input type="text"/>				
Third Party Liability Amount:	<input type="text"/>								
Diagnosis Pointers: 1:	<input type="text"/>	2:	<input type="text"/>	3:	<input type="text"/>	4:	<input type="text"/>		
Prior Authorization Number:	<input type="text"/>								
Rendering Provider ID (If different from header):	<input type="text"/>			Type:	<input type="text"/>			Taxonomy Code:	<input type="text"/>
Supervising Provider ID (If different from header):	<input type="text"/>			Type:	<input type="text"/>				



# Basic Line Item Information – Dental (5 of 11)

The **Tooth Information** section is collapsed by default.

6. To enter relevant tooth information, select the plus icon (+). The **Tooth Information** section expands.
  - a. Enter the relevant information in the **Tooth Number/Letter** field.
  - b. Enter the relevant information in the **Tooth Surface** fields.
  - c. Complete the **Procedure Code** field.
  - d. Complete the **Quantity** field.

 BASIC LINE ITEM INFORMATION 

**BASIC SERVICE LINE ITEMS**

Service Date: 

MM  DD  CCYY


Appliance Placement Date: 

MM  DD  CCYY

Place of Service (If different from header):

Oral Cavity Designation: 1:  2:  3:  4:  5:

Fees:

 **Tooth Information**

1. 

Tooth Number/Letter: 

Add Another:

Tooth Surface: 1:  2:  3:  4:  5:

Procedure Code: 

Quantity:

85

# Basic Line Item Information – Dental (6 of 11)

7. Complete the **Third Party Liability Amount** field.
8. Select a Diagnosis Pointer—the diagnostic reference number (one through four from the **Bill Information** section) to relate the date of service and procedure performed to the appropriate diagnosis code—from the **Diagnosis Pointers** drop-down lists.

Procedure Code:	<input type="text"/>	Quantity:	<input type="text"/>
Third Party Liability Amount:	<input type="text"/>		
Diagnosis Pointers:	1: <input type="text"/>	2: <input type="text"/>	3: <input type="text"/> 4: <input type="text"/>
Prior Authorization Number:	<input type="text"/>		
Rendering Provider ID (If different from header):	<input type="text"/>	Type:	<input type="text"/>
Supervising Provider ID (If different from header):	<input type="text"/>	Type:	<input type="text"/>
Taxonomy Code: <input type="text"/>			
<b>Additional Service Line Information</b>			
Prosthesis, Crown or Inlay Code:	<input type="text"/>	Replacement Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
		Prior Placement Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
<input type="button" value="Add Service Line Item"/> <input type="button" value="Update Service Line Item"/>			

# Basic Line Item Information – Dental (7 of 11)

9. Complete the **Prior Authorization Number** field.

Procedure Code:	<input type="text"/>	Quantity:	<input type="text"/>
Third Party Liability Amount:	<input type="text"/>		
Diagnosis Pointers:	1: <input type="text"/>	2: <input type="text"/>	3: <input type="text"/> 4: <input type="text"/>
Prior Authorization Number:	<input type="text"/>		
Rendering Provider ID (if different from header):	<input type="text"/>	Type:	<input type="text"/>
Supervising Provider ID (if different from header):	<input type="text"/>	Type:	<input type="text"/>
Taxonomy Code: <input type="text"/>			
<b>Additional Service Line Information</b>			
Prosthesis, Crown or Inlay Code:	<input type="text"/>	Replacement Date:	<input type="text"/> <input type="text"/> <input type="text"/>
			<input type="text"/> <input type="text"/> <input type="text"/>
<input type="button" value="Add Service Line Item"/> <input type="button" value="Update Service Line Item"/>			

# Basic Line Item Information – Dental(8 of 11)

10. Complete the following fields as applicable:

- If the rendering provider, ordering provider, or supervising provider is the same as the header provider information, then leave blank.
- If the rendering provider or supervising provider differ from the header provider information input during the **Provider Information** section, enter the National Provider ID (NPI) in the **Rendering Provider ID** or **Supervising Provider ID** fields and select **NPI** from the corresponding **Type** drop-down list.

**Note:** If a rendering provider NPI is submitted, providers are encouraged to also enter the appropriate taxonomy code.

Procedure Code:	<input type="text"/>	Quantity:	<input type="text"/>
Third Party Liability Amount:	<input type="text"/>		
Diagnosis Pointers:	1: <input type="text"/>	2: <input type="text"/>	3: <input type="text"/> 4: <input type="text"/>
Prior Authorization Number:	<input type="text"/>		
Rendering Provider ID (If different from header):	<input type="text"/>	Type:	<input type="text"/>
Supervising Provider ID (If different from header):	<input type="text"/>	Type:	<input type="text"/>
Taxonomy Code: <input type="text"/>			
<b>Additional Service Line Information</b>			
Prosthesis, Crown or Inlay Code:	<input type="text"/>	Replacement Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
		Prior Placement Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
<input type="button" value="Add Service Line Item"/> <input type="button" value="Update Service Line Item"/>			

# Basic Line Item Information – Dental (9 of 11)

11. Enter the rendering provider's taxonomy code in the **Taxonomy Code** field.

BASIC LINE ITEM INFORMATION									
<b>BASIC SERVICE LINE ITEMS</b>									
Service Date:	MM	DD	CCYY		Appliance Placement Date:	MM	DD	CCYY	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	*		<input type="text"/>	<input type="text"/>	<input type="text"/>	
Place of Service (If different from header):	<input type="text"/>								
Oral Cavity Designation:	1:	<input type="text"/>	2:	<input type="text"/>	3:	<input type="text"/>	4:	<input type="text"/>	5:
Fees:	<input type="text"/>								
Procedure Code:	<input type="text"/>			*	Quantity:	<input type="text"/>			
Third Party Liability Amount:	<input type="text"/>								
Diagnosis Pointers:	1:	<input type="text"/>	2:	<input type="text"/>	3:	<input type="text"/>	4:	<input type="text"/>	
Prior Authorization Number:	<input type="text"/>								
Rendering Provider ID (If different from header):	<input type="text"/>				Type:	<input type="text"/>		Taxonomy Code: <input type="text"/>	
Supervising Provider ID (If different from header):	<input type="text"/>				Type:	<input type="text"/>			

# Basic Line Item Information – Dental (10 of 11)

**Note:** The **Additional Service Line Information** section is collapsed by default.

- Providers can select the plus icon (+) to expand this section to enter relevant information in the **Additional Service Line Information** section.
- If this section is no longer needed, providers can select the minus icon (–) to minimize it.

Procedure Code:	<input type="text"/>	Quantity:	<input type="text"/>
Third Party Liability Amount:	<input type="text"/>		
Diagnosis Pointers:	1: <input type="text"/>	2: <input type="text"/>	3: <input type="text"/> 4: <input type="text"/>
Prior Authorization Number:	<input type="text"/>		
Rendering Provider ID (If different from header):	<input type="text"/>	Type:	<input type="text"/>
Supervising Provider ID (If different from header):	<input type="text"/>	Type:	<input type="text"/>
<div><div></div> Additional Service Line Information</div>			
Prosthesis, Crown or Inlay Code:	<input type="text"/>	Replacement Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
		Prior Placement Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
<div><div></div> Add Service Line Item <div></div> Update Service Line Item</div>			

# Basic Line Item Information – Dental (11 of 11)

12. To include the line item in the bill, select **Add Service Line Item**. Repeat this process for each additional line. A window displays to confirm the Service Line is added successfully.

13. Select **OK** to close the window.

**Note:** Providers can select **Update Service Line Item** to make corrections and enter missing information to a line item that was previously added.

Procedure Code:	<input type="text"/>	Quantity:	<input type="text"/>
Third Party Liability Amount:	<input type="text"/>		
Diagnosis Pointers:	1: <input type="text"/>	2: <input type="text"/>	3: <input type="text"/> 4: <input type="text"/>
Prior Authorization Number:	<input type="text"/>		
Rendering Provider ID (If different from header):	<input type="text"/>	Type:	<input type="text"/>
Supervising Provider ID (If different from header):	<input type="text"/>	Type:	<input type="text"/>
Taxonomy Code: <input type="text"/>			
<b>Additional Service Line Information</b>			
Prosthesis, Crown or Inlay Code:	<input type="text"/>	Replacement Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
		Prior Placement Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
<input type="button" value="Add Service Line Item"/> <input type="button" value="Update Service Line Item"/>			

# Previously Entered Line Item Information – Dental

Once a line item has been added, the line item information displays.

1. Proceed with the line item information as follows:

- To update the line item information, select the **Line No** link.
- To remove the line item, select the **Delete** link.

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Total Fee: \$345.00

Line No	Procedure Code	Fees	Diagnosis Pntrs				Oral Cavity					Quantity	Service Date/ Treatment Start Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	5						
1	D4150	\$345.00	1				10					2	02/15/2020	02/15/2020			Delete

2. Once the provider has entered all line items scroll back to the top of the page and select **Submit Bill** to submit the bill.

**Note:** The provider also has the option to save the bill and return later or reset the bill to start over. To view the steps on retrieving a saved bill, proceed to the [Retrieving Saved Bills](#) section of this document.



**Note:** Saved bills are available under the **Retrieve Saved Bills** menu for a later submission.

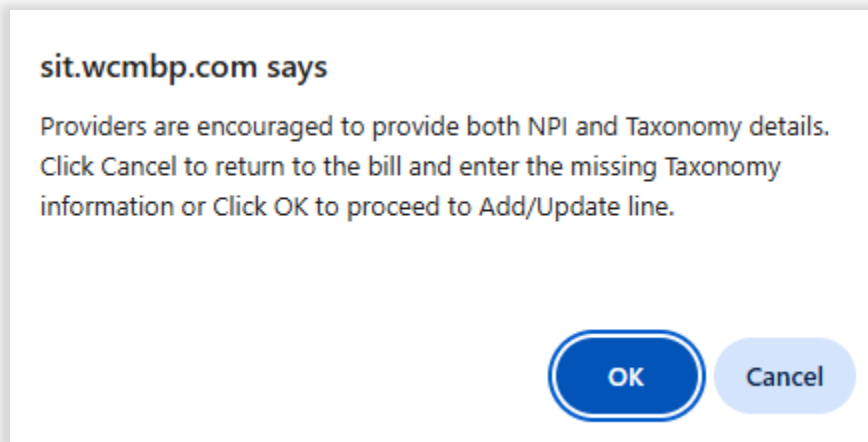


# Bill Information – Add or Update Service Line Warning

If the provider enters one item (rendering provider NPI or rendering taxonomy code), the other item is recommended to be entered. The system will return a message indicating that both items are encouraged.

When this system message is received, proceed as applicable.

- To return to the bill and enter the missing taxonomy, select **Cancel**.
- To proceed to add or update the line, select **OK**.

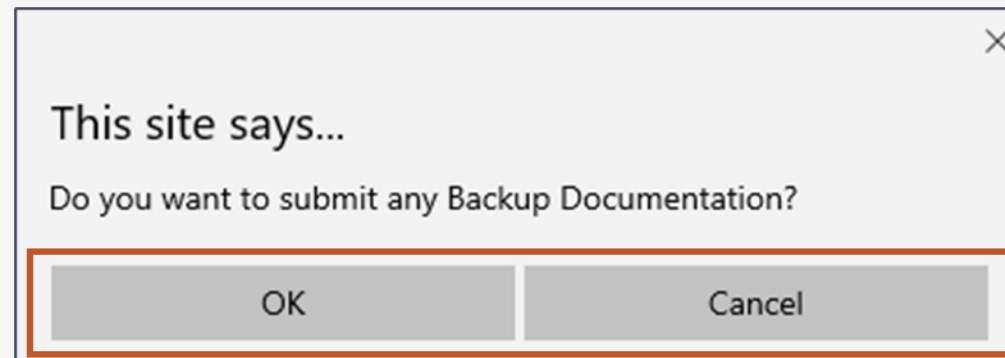


# Adding an Attachment – Dental (1 of 3)

When selecting **OK** to proceed to add or update the line, a popup window opens with the message "Do you want to submit any Backup Documentation?"

1. Proceed as applicable:

- To add attachments, select **OK**. The **Add Attachments** window opens.
- To proceed without attachments (no attachment is needed), select **Cancel**. The submitted professional bill details display.



# Adding an Attachment – Dental (2 of 3)

- In the **Add Attachments** window, select the **Attachment Type** being submitted for the services rendered and select the **Transmission Code**.

**Note:** Attachments can only be attached if selecting Transmission Code of **EL** or **FT**.

Please select one of the option from the Required Fields \* and select Line No, if the attachment is for specific Service Line Item.

**Attachment Type:** 03-03-Report Justifying Treatment f \*  
**Transmission Code:** EL-Electronically Only \*

Line No:  (Do not select Line No to attach a document at header level)

**Please attach the File(s). The File Format must be PDF,TIF,TIFF**

Upload File

Please be sure the supporting documentation/attachments is for the treated claimant ONLY.  
Please do not upload supporting documentation/attachments for any other claimant as this could potentially cause a denial of your bill or an unintended disclosure of protected health information (PHI).

OK Cancel

- A-Available on Request at Provid
- M-By Mail
- L-Electronically Only
- M-E-Mail
- T-FT-File Transfer
- X-By-Fax

- To locate and add the attachment, select **Upload File**, then select **OK**.

Please select one of the option from the Required Fields \* and select Line No, if the attachment is for specific Service Line Item.

**Attachment Type:** 03-03-Report Justifying Treatment f \*  
**Transmission Code:** EL-Electronically Only \*

Line No:  (Do not select Line No to attach a document at header level)

**Please attach the File(s). The File Format must be PDF,TIF,TIFF**

Upload File

Please be sure the supporting documentation/attachments is for the treated claimant ONLY.  
Please do not upload supporting documentation/attachments for any other claimant as this could potentially cause a denial of your bill or an unintended disclosure of protected health information (PHI).

OK Cancel

# Adding an Attachment – Dental (3 of 3)

Once the **Submit Bill** tab is selected, the Transaction Control Number (TCN) displays and the option to add additional attachments displays. Once the attachment is added, it will be listed in the **Attachment List** section.

- To complete the attestation, select the **SIGNATURE OF PHYSICIAN OR SUPPLIER** checkbox.

Submitted Dental Bill Details

The 'Submit' button must be clicked to send the Bill for processing. If not, the Bill will be available under 'Retrieve Saved Bills' menu for later submission.

Transaction Control Number (TCN): [REDACTED]  
Provider ID: [REDACTED]  
Claimant ID: [REDACTED]  
Date of Service: 10/31/2023-10/31/2024  
Total Bill Charges: \$ 600.00

☐ **SIGNATURE OF PHYSICIAN OR SUPPLIER**

Checking this box 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). Checking this box 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, BLBA 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 acknowledgement indicates that you understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Please click "Add Attachment" button, to attach the documents.

Add Attachment

Attachment List

<input type="checkbox"/>	Line No ▲▼	File Name ▲▼	Attachment Type ▲▼	Transmission Code ▲▼	Attachment Control # ▲▼	File Size ▲▼	Delete ▲▼	Uploaded On ▲▼
<input type="checkbox"/>	1	Supporting Document.pdf	03	EL	201446514	27kb	X	05/07/2025

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Print Print Cover Page Submit

SaveToCSV

# Submitted Dental Bill Details

5. To submit the bill, select **Submit**. Once submitted, the “Do you want to Submit another Bill?” confirmation alert message displays.



**Important:** For transmission codes of AA, BM, EM and FX, the provider will need to select **Print Cover Page** to mail or fax the attachments. Refer to [How to View PDFs Using Adobe Reader](#) for instructions on how to view PDFs using Adobe Reader.

Submitted Dental Bill Details

The 'Submit' button must be clicked to send the Bill for processing. If not, the Bill will be available under 'Retrieve Saved Bills' menu for later submission.

Transaction Control Number (TCN): [REDACTED]  
Provider ID: [REDACTED]  
Claimant ID: [REDACTED]  
Date of Service: 10/31/2023-10/31/2024  
Total Bill Charges: \$ 600.00

☐ **SIGNATURE OF PHYSICIAN OR SUPPLIER**

Checking this box 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). Checking this box 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, BLBA 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 acknowledgement indicates that you understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Please click "Add Attachment" button, to attach the documents.

Add Attachment

Attachment List

<input type="checkbox"/>	Line No ▲▼	File Name ▲▼	Attachment Type ▲▼	Transmission Code ▲▼	Attachment Control # ▲▼	File Size ▲▼	Delete ▲▼	Uploaded On ▲▼
<input type="checkbox"/>	1	Supporting Document.pdf	03	EL	201446514	27kb	X	05/07/2025

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Save To CSV

Print Print Cover Page Submit

# Missing or Invalid Data Message – Dental

If the **Billing NPI** code is missing, a warning message will display.

- Providers are encouraged to submit Billing NPI at header

If the **Taxonomy Code** is missing or invalid, a warning message will display.

- Providers are encouraged to submit taxonomy details for Billing Provider and NPI or taxonomy details for Rendering Provider at header and lines.
- Review the following missing NPI or taxonomy information:
  - Billing Provider Information - Taxonomy Code
  - Rendering Provider - Taxonomy Code
  - Line Rendering Provider - Taxonomy Code for Lines

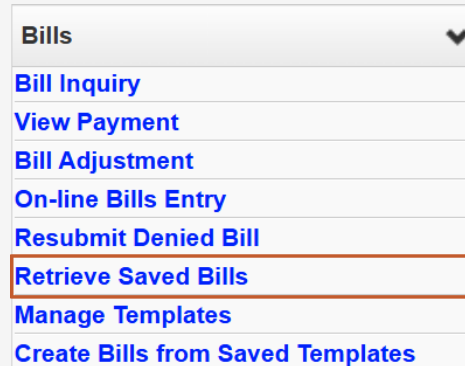
**Note:** The provider can select **Cancel** to return to the bill and enter the details or they can select **OK** to proceed with submission.

## Retrieving Saved Bills

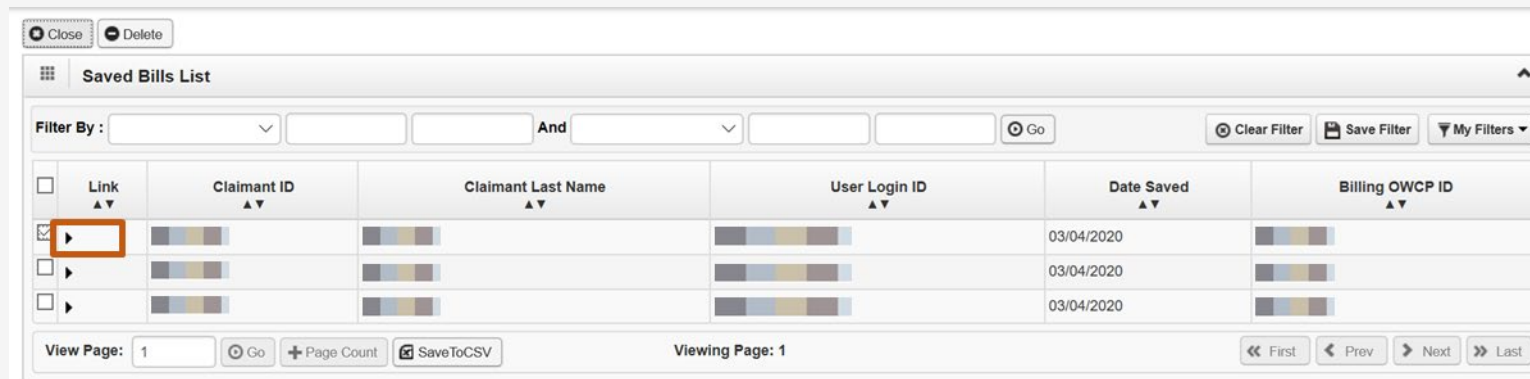


# Retrieving Saved Bills

1. Select the **Retrieve Saved Bills** link under **Bills**. A link of all saved bills displays.



2. From the **Link** column, select the right-facing triangle icon. The system displays the corresponding bill (Professional, Institutional, or Dental Bill) that was previously saved.



3. Continue making changes and submit the bill.



## Billing Additional Information



# Billing – Additional Information

- Prior to submitting bills:
  - Check claimant eligibility
  - Check to see if an authorization is required
  - Confirm authorizations are approved
- It takes up to 28 days to process a bill submitted via mail
- EFT payments differ depending on the program
  - DCMWC payments are paid on Wednesdays
  - DEEOIC payments are paid on Thursdays
  - DFEC payments are paid on Fridays
- For providers who elect against electronic correspondence, Explanation of Benefits (EOB) are mailed to the mailing address on file on the Monday prior to the EFT Payment
- It takes eight business days to process an Adjustment
- System features allow users to create and update bill templates
- Create bills from saved templates
- EDI bills are processed **three times faster** than mail and DDE bills
- Review the Fee Schedule to see what services are covered by DOL

## Adding Attachments After Bill Submission in the WCMBP System

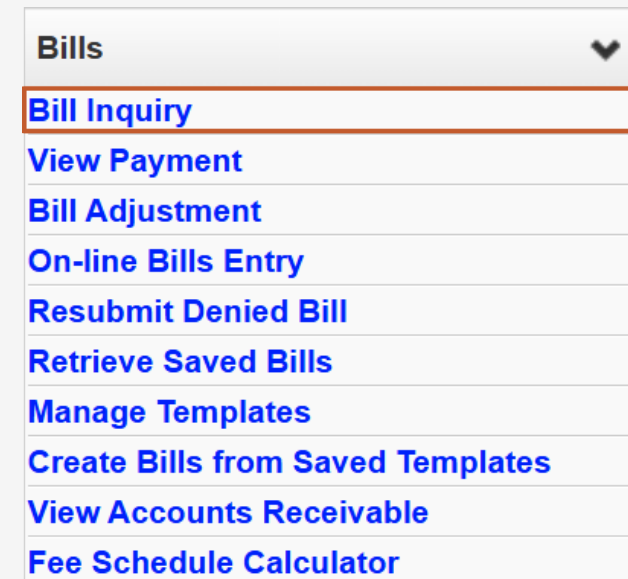


# Adding an Attachment to “In Process” Status Bills (1 of 6)

The Bill Inquiry process is consistent across all three bill submission types (Professional, Institutional, and Dental). This section provides a unified approach to reviewing and managing bills, ensuring that the same steps apply regardless of the bill type being submitted.

- Attachments can be added to a submitted bill when the bill status is “In Process.”
- Attachments cannot be added to a submitted bill with other status types.

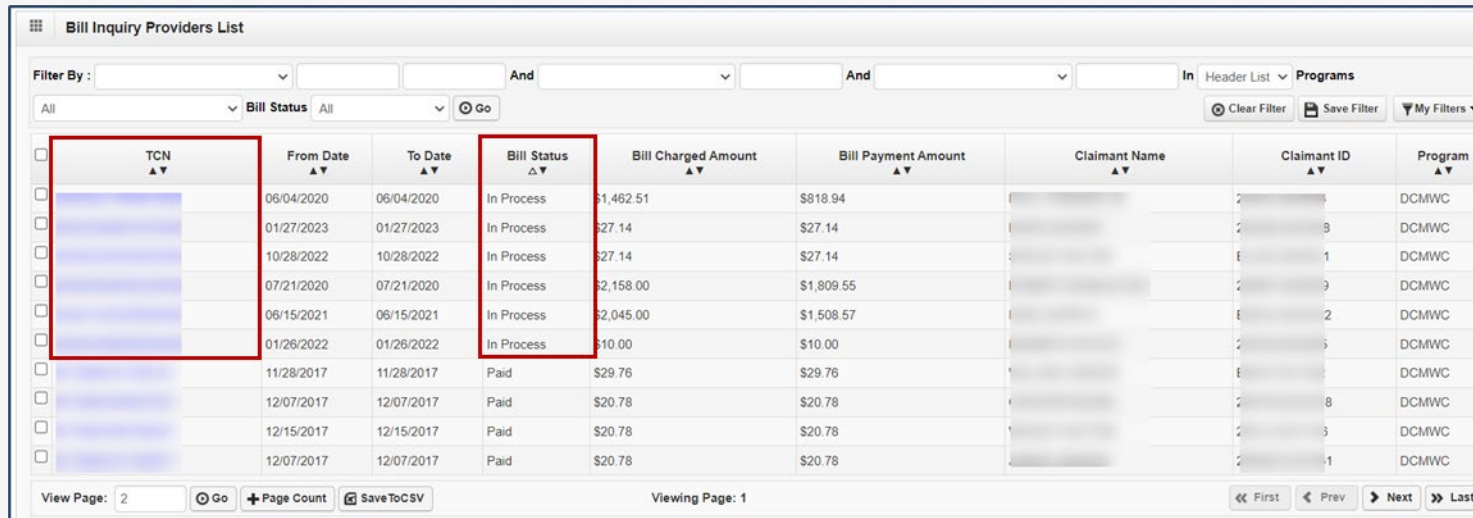
1. To initiate this process, select the **Bill Inquiry** link under **Bills**.



# Adding an Attachment to "In Process" Status Bills (2 of 6)

The system only displays bills processed within the last seven years.

By default, search results are limited to the most recent 100 bills; however, providers can use filters to display all bills that meet the specified criteria.



TCN ▲▼	From Date ▲▼	To Date ▲▼	Bill Status ▲▼	Bill Charged Amount ▲▼	Bill Payment Amount ▲▼	Claimant Name ▲▼	Claimant ID ▲▼	Program ▲▼
	06/04/2020	06/04/2020	In Process	\$1,462.51	\$818.94		2	DCMWC
	01/27/2023	01/27/2023	In Process	\$27.14	\$27.14		3	DCMWC
	10/28/2022	10/28/2022	In Process	\$27.14	\$27.14		1	DCMWC
	07/21/2020	07/21/2020	In Process	\$2,158.00	\$1,809.55		9	DCMWC
	06/15/2021	06/15/2021	In Process	\$2,045.00	\$1,508.57		2	DCMWC
	01/26/2022	01/26/2022	In Process	\$10.00	\$10.00		5	DCMWC
	11/28/2017	11/28/2017	Paid	\$29.76	\$29.76		8	DCMWC
	12/07/2017	12/07/2017	Paid	\$20.78	\$20.78		3	DCMWC
	12/15/2017	12/15/2017	Paid	\$20.78	\$20.78		1	DCMWC
	12/07/2017	12/07/2017	Paid	\$20.78	\$20.78		1	DCMWC

# Adding an Attachment to "In Process" Status Bills (3 of 6)

2. Complete these steps to add an attachment:
  - a. Select the **TCN** link for the "In Process" bill.

<input type="checkbox"/>	TCN ▲▼	From Date ▲▼	To Date ▲▼	Bill Status ▲▼	Bill Charged Amount ▲▼	Bill Payment Amount ▲▼	Claimant Name ▲▼	Claimant ID ▲▼	Program ▲▼
<input type="checkbox"/>	<a href="#">310124128046472000</a>	06/04/2020	06/04/2020	In Process	\$1,462.51	\$818.94	P [REDACTED] JR	2 [REDACTED]	DCMWC

- b. Select **View/Add Attachment**.

Close **View/Add Attachment** View/Add Attachment

Bill Details

TCN: 32 [REDACTED] 00  
Parent TCN:  
From DOS - To DOS: 10/28/2022 - 10/28/2022  
Received Date: 11/18/2022  
Check/EFT Trace Number: 7122581  
Patient Control Number:

Program: DCMWC  
Original TCN:  
Billed Amount: \$27.14  
Adjudication Date: 11/18/2022  
RV Number: 0000000

Bill Status: In Process  
Paid Amount: \$27.14  
Check/EFT Trace Date: 11/30/2022  
Authorization Number:

Billing Provider Name: D [REDACTED] MEDICAL SERVICES  
Billing Provider NPI: 1 [REDACTED] 1

OWCP ID: 000000000  
Billing Provider Taxonomy Code:

Tax ID: [REDACTED]

- c. Select **Upload Images/Attachments**.

Provider Portal > Bill Inquiry Providers List > Bill Details > Images/Attachment List

TCN ID: 310124128046472000

Close **Upload Images/Attachments**

Images/Attachments Retrieval Page

Filter By : ▼  And ▼  And ▼  And ▼  Go

Image ID ▲▼	Image Title ▲▼	Created By ▲▼	Created Date ▲▼	Receive ▲
<a href="#">ATT773280754</a> <a href="#">OI10506050</a>	4127307336 TIF	SUNUSAT	05/07/2024	05/06/2024

# Adding an Attachment to "In Process" Status Bills (4 of 6)

**Note:** If the error message "The bill processing is complete, and additional attachments cannot be added" appears, it is because although the bill may show as "In Process" on the portal, it is awaiting the payment decision. When this error message appears, the option to add attachments is not available.

Close Upload Images/Attachments

Warning! The bill processing is complete and additional attachments cannot be added.

Images/Attachments Retrieval Page

Filter By :   And   And   And   Go



Clear Filter Save Filter My Filters

Image ID ▲▼	Image Title ▲▼	Created By ▲▼	Created Date ▲▼	Received Date ▲▼	TCN ▲▼
<a href="#">ATT720789368_OH1205146</a>	3339002483.TIF	supuser	12/06/2023	12/05/2023	

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# Adding an Attachment to "In Process" Status Bills (5 of 6)

3. To upload documentation, select **Upload File**.

 Please attach the File(s). The File Format must be PDF,TIF,TIFF 

Upload File



No file uploaded \*

Please be sure the supporting documentation/attachments is for the treated claimant ONLY.  
Please do not upload supporting documentation/attachments for any other claimant as this could potentially cause a denial of your bill or an unintended disclosure of protected health information (PHI).

✓ OK

✗ Cancel

4. Select **OK**.

 Please attach the File(s). The File Format must be PDF,TIF,TIFF 

Upload File

Supporting Document.pdf \*

Please be sure the supporting documentation/attachments is for the treated claimant ONLY.  
Please do not upload supporting documentation/attachments for any other claimant as this could potentially cause a denial of your bill or an unintended disclosure of protected health information (PHI).

✓ OK

✗ Cancel



# Adding an Attachment to “In Process” Status Bills (6 of 6)

The system displays the uploaded file in the **Image/Attachments Retrieval Page** section.

5. To view the file, select the **Image ID** link.

[Home](#) > [Provider Portal](#) > [Bill Inquiry Providers List](#) > [Bill Details](#) > [Images/Attachment List](#)

TCN ID:

Close

Upload Images/Attachments

Images/Attachments Retrieval Page

^

Filter By :

AndAndAnd

Go

Clear Filter

Save Filter

My Filters

Image ID ▲▼	Image Title ▲▼	Created By ▲▼	Created Date ▲▼	Received Date ▲▼	TCN ▲▼
<a href="#">ATTCP723998776</a>	Test portal attachment - Copy.pdf		03/24/2025	03/24/2025	
<a href="#">ATTCP723998774</a>	Test portal attachment.pdf		03/24/2025	03/24/2025	

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# THANK YOU!

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