Carrier Reimbursement Tutorial

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- Where to access the Carrier Reimbursement Template
- How to complete the Carrier Reimbursement Template
- How to submit the Carrier Reimbursement Template

Overview

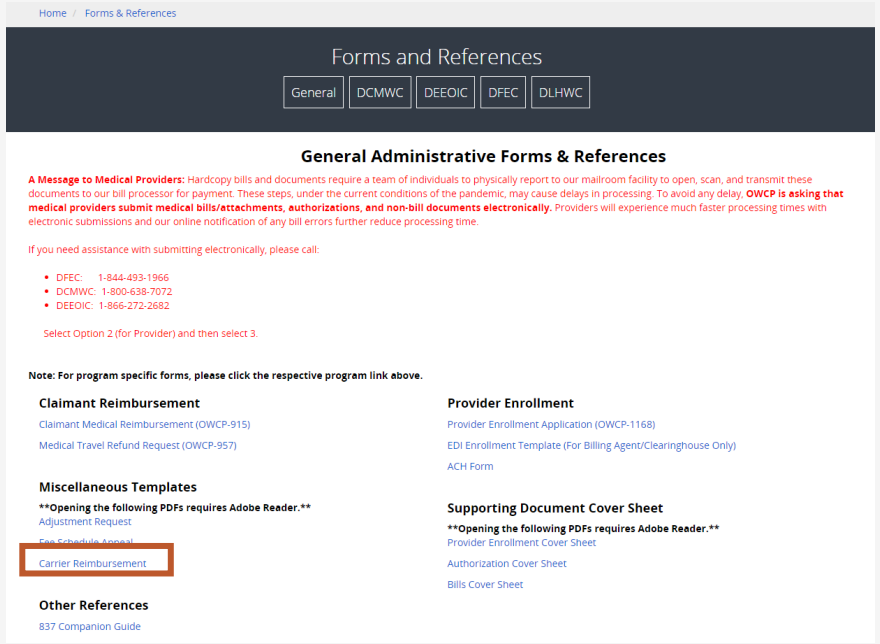
The Carrier Reimbursement Template is used by Providers enrolled with DFEC, DEEOIC and DCMWC programs under Provider Type 95 to submit bills. This template is used by healthcare insurance carriers and other fee-for-service health plans seeking reimbursement for claims related to an existing workers' compensation claims.

The Carrier Reimbursement Template can be found on the Medical Bill Processing Portal under Resources-Forms & References. The original HCFA1500 also known as OWCP 1500 for professional services, and/or the original UB04 also known as OWCP 04 for Inpatient or Outpatient services as well as any other supporting documentation required by OWCP or program policy, must be attached to the submitted Carrier Reimbursement Template.

If the completed Carrier Reimbursement Template is received without the required attachments, the submitted completed template will be returned to the carrier, using the Returned to Provider (RTP) processing structure.

Accessing the Carrier Reimbursement Template

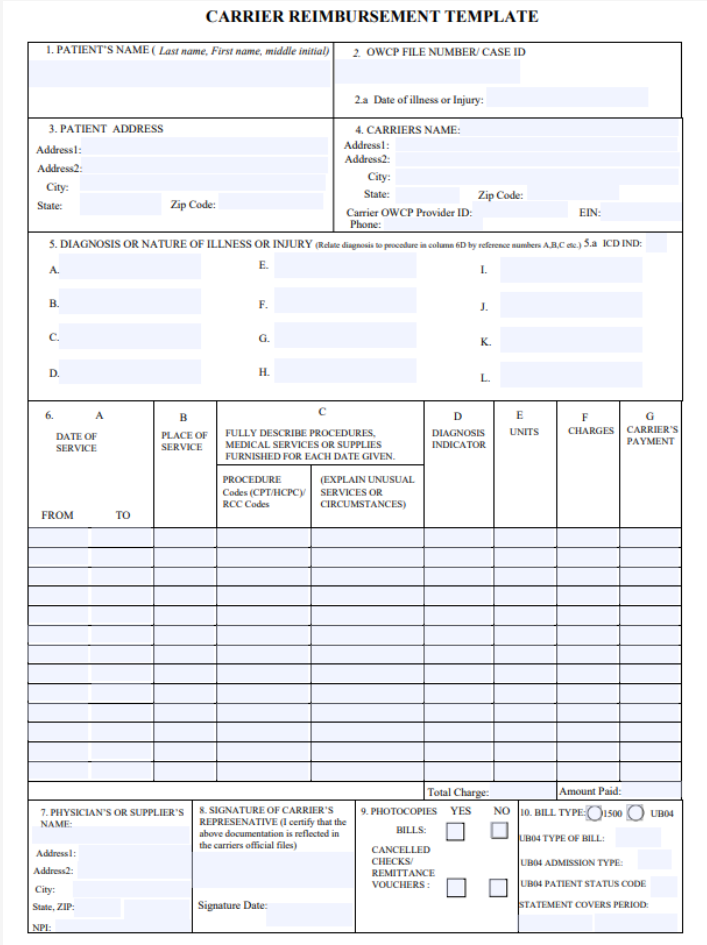
On the Medical Bill Processing Portal https://owcpmed.dol.gov/portal/, the Carrier Reimbursement Template can be accessed under Resources - General - Forms & References, under the “Miscellaneous Templates” category.



Carrier Reimbursement Template

This template should only be used by Providers enrolled under Provider Type 95 (Insurance Company, Third Party Carriers)

This applies to all three OWCP programs: DFEC, DEEOIC and DCMWC.



CARRIER REIMBURSEMENT TEMPLATE

1. PATIENT'S NAME (*Last name, First name, middle initial)*

2. OWCP FILE NUMBER/ CASE ID

2.a Date of illness or Injury:

3. PATIENT ADDRESS
Address1:
Address2:
City:
State: Zip Code:

4. CARRIERS NAME:
Address1:
Address2:
City:
State: Zip Code:
Carrier OWCP Provider ID: EIN:
Phone:

5. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate diagnosis to procedure in column 6D by reference numbers A,B,C etc.) 5.a ICD IND:

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

6. A DATE OF SERVICE FROM TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE Codes (CPT/HCPC)/ RCC Codes	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS INDICATOR	E UNITS	F CHARGES	G CARRIER'S PAYMENT
				Total Charge:		Amount Paid:	

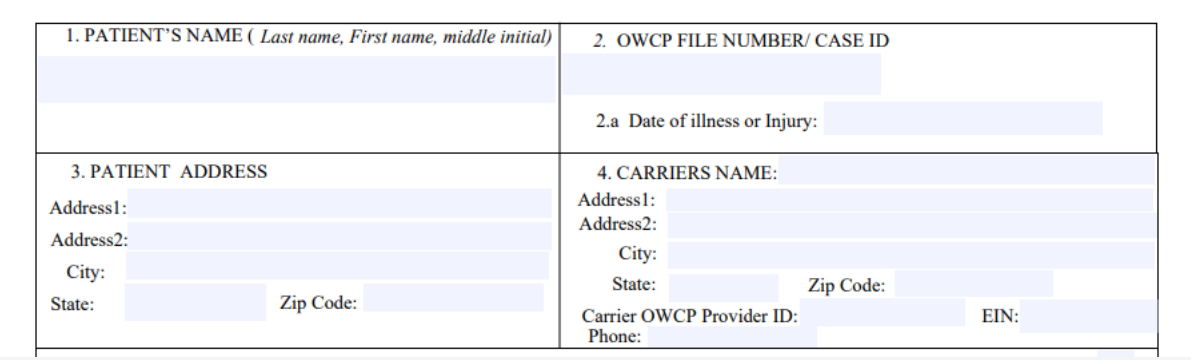
7. PHYSICIAN'S OR SUPPLIER'S NAME:
Address1:
Address2:
City:
State, ZIP:
NPI:

8. SIGNATURE OF CARRIER'S REPRESENATIVE (I certify that the above documentation is reflected in the carriers official files)
Signature Date:

9. PHOTOCOPIES YES NO
BILLS:
CANCELLED CHECKS/ REMITTANCE VOUCHERS :

10. BILL TYPE: 1500 UB04
UB04 TYPE OF BILL:
UB04 ADMISSION TYPE:
UB04 PATIENT STATUS CODE
STATEMENT COVERS PERIOD:

Completing the Carrier Reimbursement Template


1. PATIENT'S NAME (*Last name, First name, middle initial)*

2. OWCP FILE NUMBER/ CASE ID

2.a Date of illness or Injury:

3. PATIENT ADDRESS

Address1:

Address2:

City:

State: Zip Code:

4. CARRIERS NAME:

Address1:

Address2:

City:

State: Zip Code:

Carrier OWCP Provider ID: EIN:

Phone:

1. Enter the Patient's name.

2. For DFEC, enter the Patient's case file number. For DEEOIC and DCMWC, enter the Case ID or SSN. **Note:** Not providing File Number/Case ID/SSN in this field can delay bill processing.

2.a. For DFEC, enter the date of illness or injury. This field is not required for DEEOIC and DCMWC.

3. Enter the Patient's address (street address, city, state, zip code).

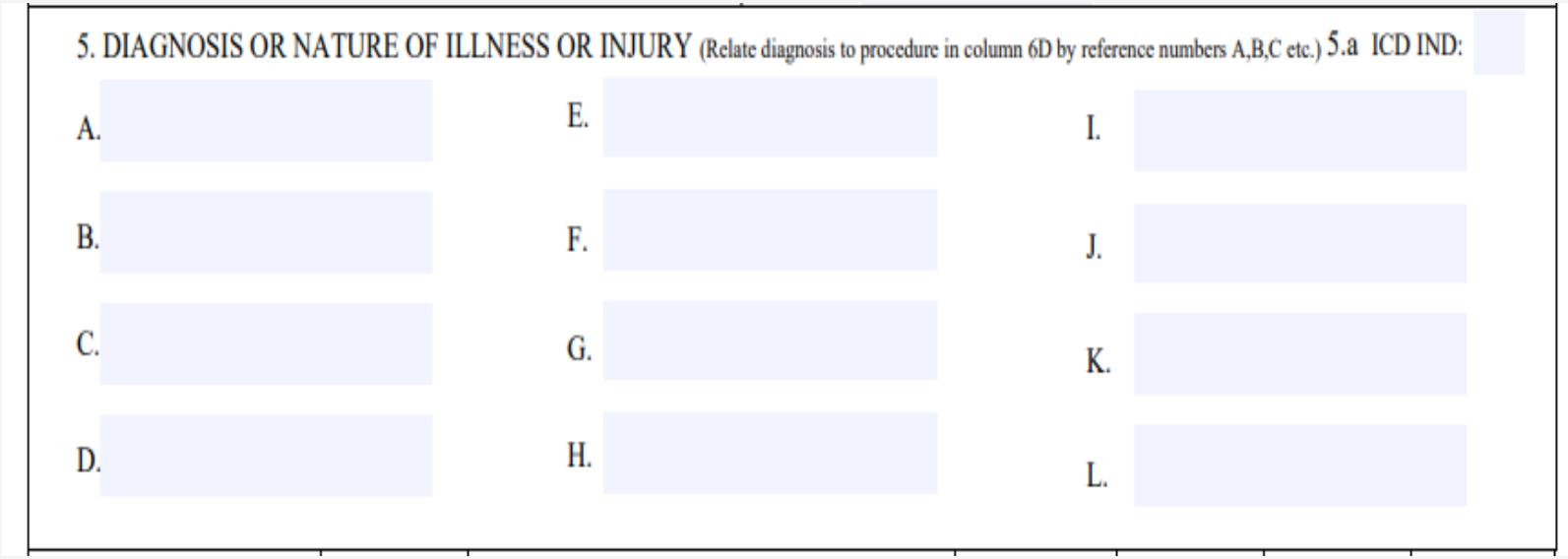
4. Enter Carrier's name address, city, state, zip code.

Enter Carrier's OWCP Provider ID, EIN (Employer Identification Number) and phone number.

Completing the Carrier Reimbursement Template

5. Enter the diagnosis code. If bill type is UB04, enter the primary diagnosis codes in field 5A.

5.a. Enter the ICD (International Classification of Diseases) diagnosis version. If using ICD-10, enter 0. If using ICD-9, enter 9.



Completing the Carrier Reimbursement Template

6A. Enter the Date of Service from and to date in the format MM/DD/YYYY.

6B. Enter the CMS/OWCP standard place of service (POS) codes.

6C. If the bill type is HCFA 1500:

- Enter the CPT/HCPCS procedure code.
- If the procedure code is unlisted J-code, enter the NDC and unit of measure (mg, ml, gram, etc.).

If the bill type is UB04:

- For Outpatient bills enter the revenue codes (RCC) and procedure code. If the procedure code is unlisted J-code, enter NDC and unit of measure (mg, ml, gram, etc.).
- For Inpatient bills, enter the revenue codes (RCC).

6. A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE Codes (CPT/HCPC)/ RCC Codes	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS INDICATOR	E UNITS	F CHARGES	G CARRIER'S PAYMENT
					Total Charge:		Amount Paid:	

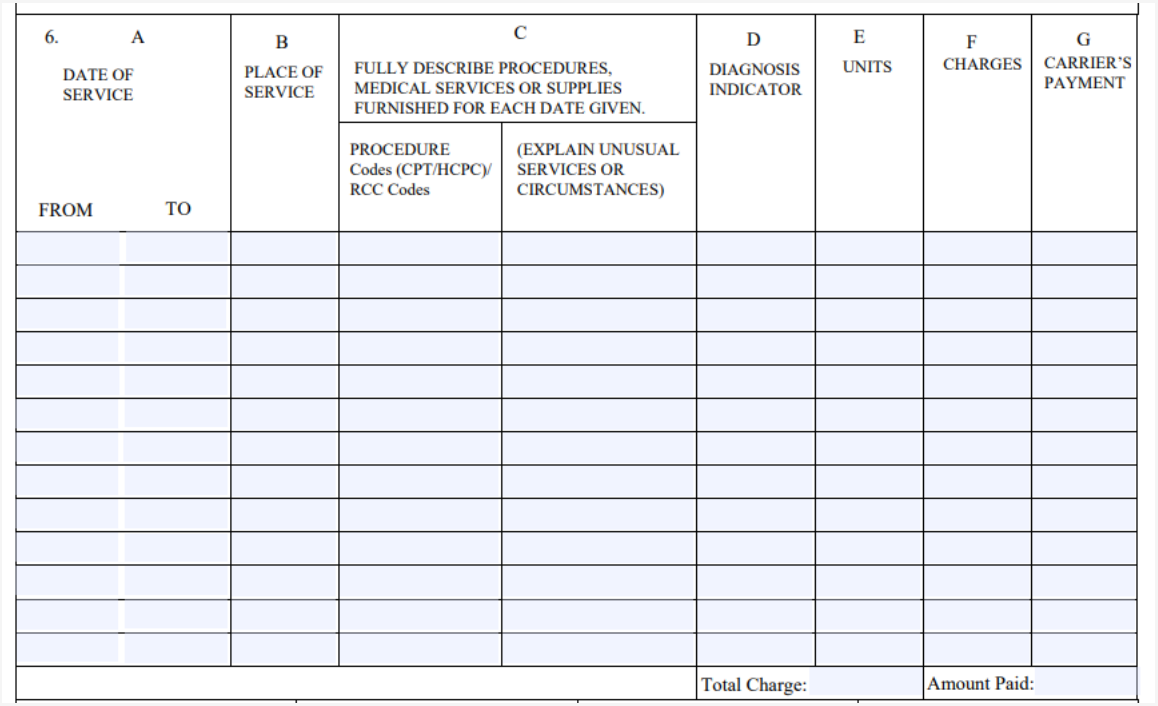
Completing the Carrier Reimbursement Template

6D. If bill type is HCFA 1500, enter a diagnosis indicator for each separate diagnosis listed in item 5 (A,B,C,D). Make sure this relates to the date of service and procedure(s) performed using appropriate ICD.

6E. Enter the number of units/services provided.

6F. Enter the charges billed by the provider to the carrier.

6G. Enter the amount paid towards the bill by the carrier.



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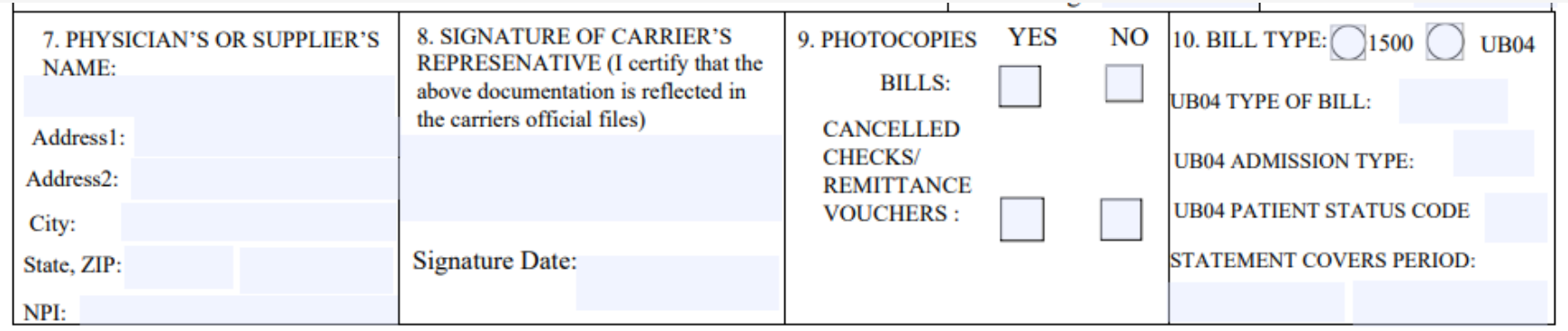
Completing the Carrier Reimbursement Template



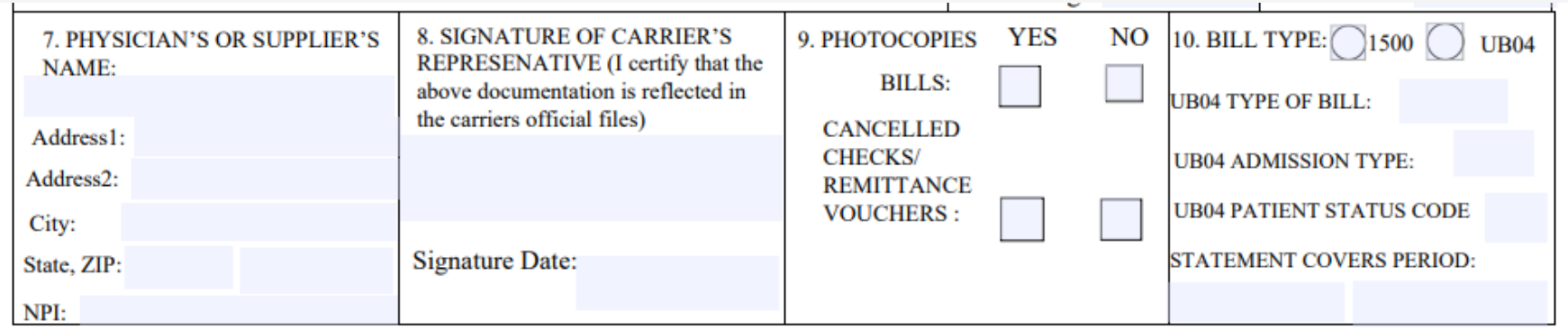
7. PHYSICIAN'S OR SUPPLIER'S NAME: Address1: Address2: City: State, ZIP: NPI:	8. SIGNATURE OF CARRIER'S REPRESENATIVE (I certify that the above documentation is reflected in the carriers official files) Signature Date:	9. PHOTOCOPIES YES NO BILLS: CANCELLED CHECKS/ REMITTANCE VOUCHERS :	10. BILL TYPE: 1500 UB04 UB04 TYPE OF BILL: UB04 ADMISSION TYPE: UB04 PATIENT STATUS CODE STATEMENT COVERS PERIOD:

7. Enter the servicing provider name, address, city, state, zip code, servicing provider NPI.

8. Sign and date the form.

9. If you have attached photocopies of bills check "yes", if not, check "no".
If you have attached cancelled checks/remittance vouchers check "yes", if not, check "no".

Completing the Carrier Reimbursement Template



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10. Check the appropriate bill type.

If the bill type is UB04,

- Enter the type of bill classification using the appropriate 3-digit code. The first digit indicates type of facility, the second digit indicates the type of care, and the third indicates the billing sequence.
- For UB04 Admission Type, enter the admission type code.
- For UB04 Patient Status Code, enter the patient status code.
- For "Statement Covers Period", enter the statement from and to date in format MM/DD/YY.

Attachments

The following documents must be attached with the Carrier Reimbursement Template, or the submitted bill will be returned to the carrier.

- The original HCFA-1500 for professional service.

  or

- The original UB04 for Inpatient and/or Outpatient services

  and

- Any other supporting documentation required by OWCP or program policy

Note: For DEEOIC and DCMWC, a cancelled check or Remittance Voucher must be attached.

Paper Bill Submission Method

For DFEC:
Mail completed bill with attachments to:
DFEC Central Mail Room, PO Box 8300, London KY 40742-8300.

For DEEOIC:
Mail completed bill with attachments to:
DEEOIC Central Mail Room, PO Box 8304, London KY 40742-8304.

For DCMWC:
Mail completed bill with attachments to:
DCMWC Central Mail Room, PO Box 8302, London KY 40742-8302.

Please allow up to 28 calendar days for bill processing.

If you need further help with completing the template, please contact the appropriate OWCP Program Toll Free: DFEC;1-844-493-1966. DEEOIC; 1-866-272-2682, and DCMWC; 1-800-638-7072

THANK YOU!