Claimant Reimbursement Forms

Overview

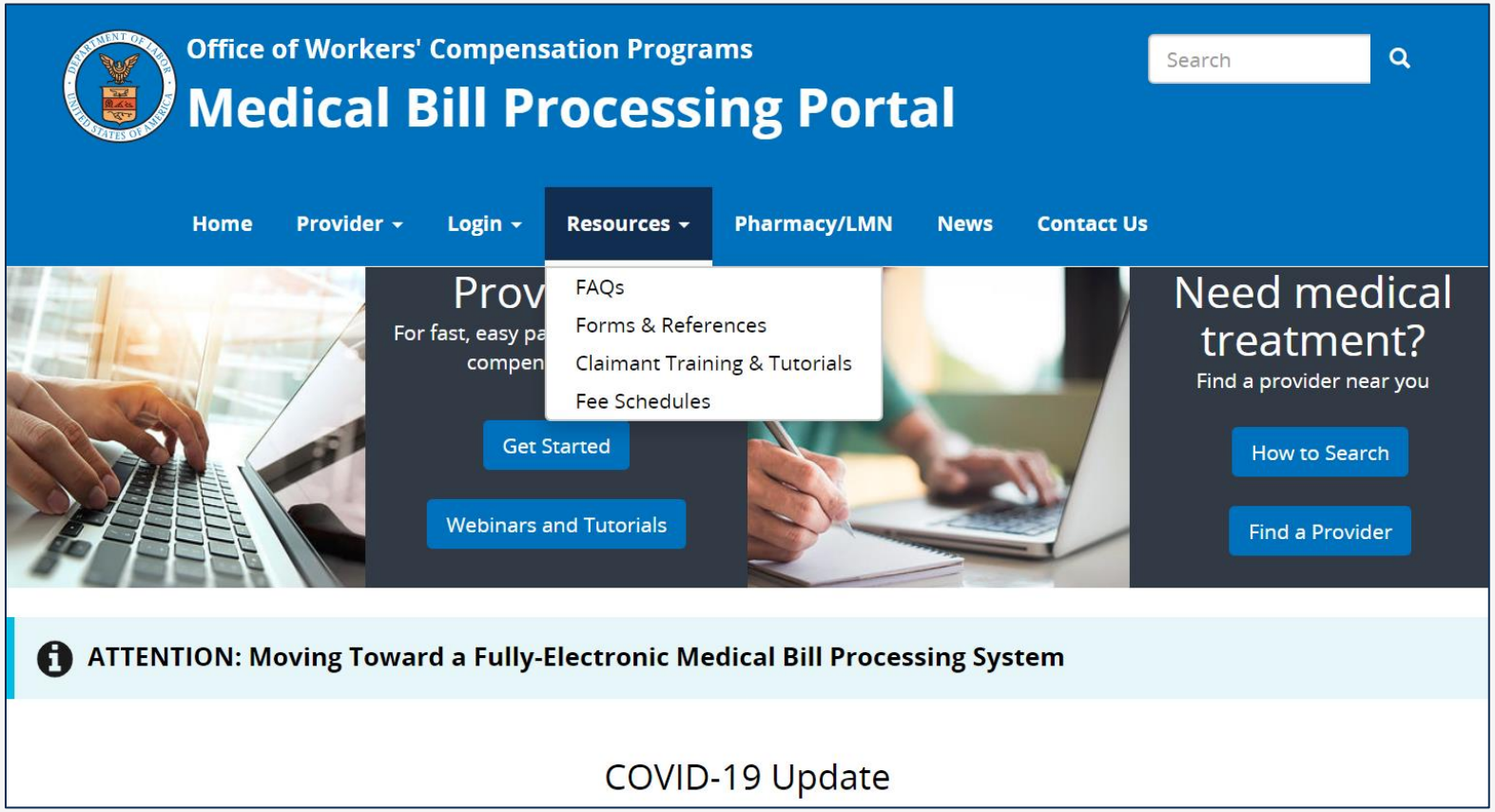
- Obtaining a Claimant Reimbursement Form
- Completing OWCP 915 for Medical Reimbursements
- Completing OWCP 915 for Pharmacy Reimbursements
- Completing OWCP 957A and 975B for Travel Reimbursements
- Reimbursement Form Submission

Obtaining a Claimant Reimbursement Form

1. **Go to** http://owcpmed.dol.gov

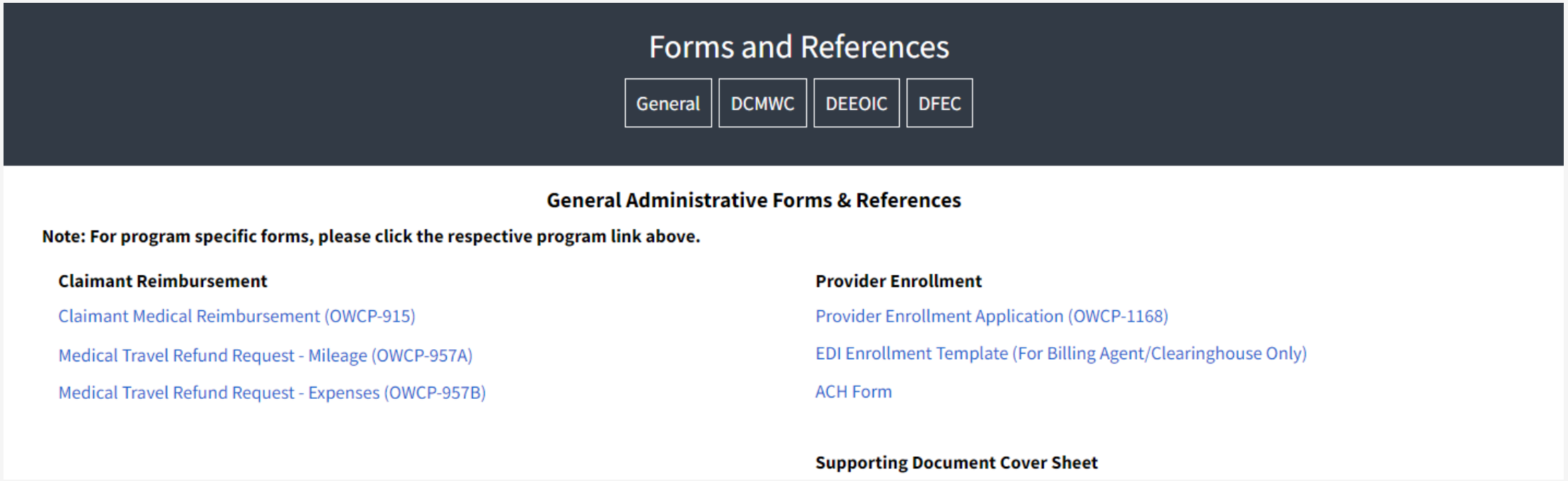
2. Click Resources

3. Click Forms & References



Obtaining a Claimant Reimbursement Form

4 Under Claimant Reimbursement, select
Claimant Medical/Pharmacy Reimbursement (OWCP 915)
or **Medical Travel Refund Request – Mileage (OWCP-957A) or Expenses (OWCP 957B)**.



OWCP 915 Medical Reimbursement

Instructions for use of FORM OWCP-915 Medical Reimbursement

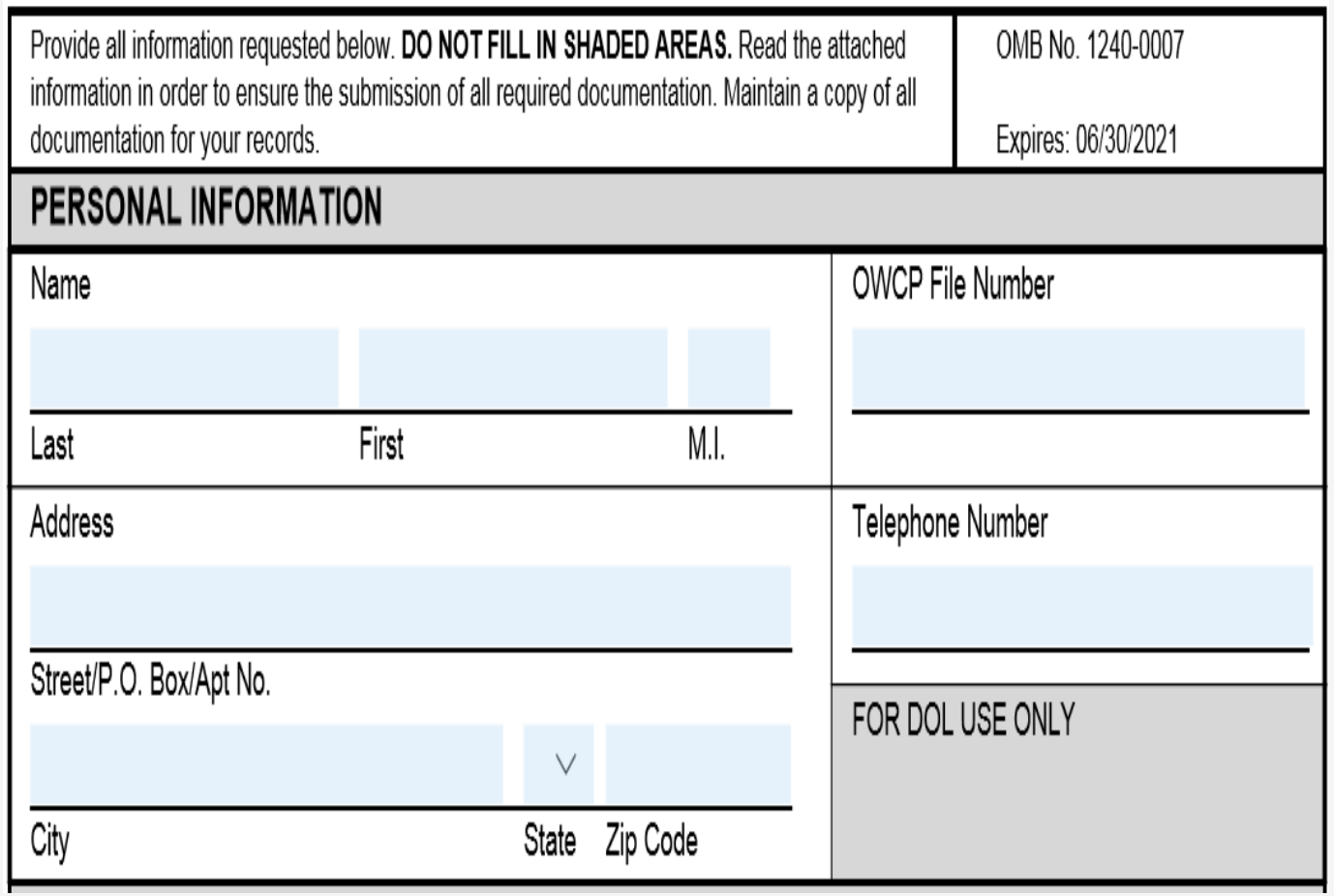
- The OWCP-915 is used to seek reimbursement for out-of-pocket medical expenses pertaining to the treatment of an accepted condition including (but not limited to) medical treatments, prescription medications and medical supplies.
- Please submit a separate reimbursement form for each provider where an out of pocket expense was incurred.
- Please print clearly and legibly. Reference your OWCP Case ID on all documentation.
- Maintain a copy of the completed OWCP-915 and supporting documentation for your records

Completing the OWCP 915 Medical Reimbursement form

1

Enter your personal information

Note: Do not enter information in the gray shaded areas



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

OMB No. 1240-0007

Expires: 06/30/2021

PERSONAL INFORMATION

Name

Last First M.I.

OWCP File Number

Address

Street/P.O. Box/Apt No.

City State Zip Code

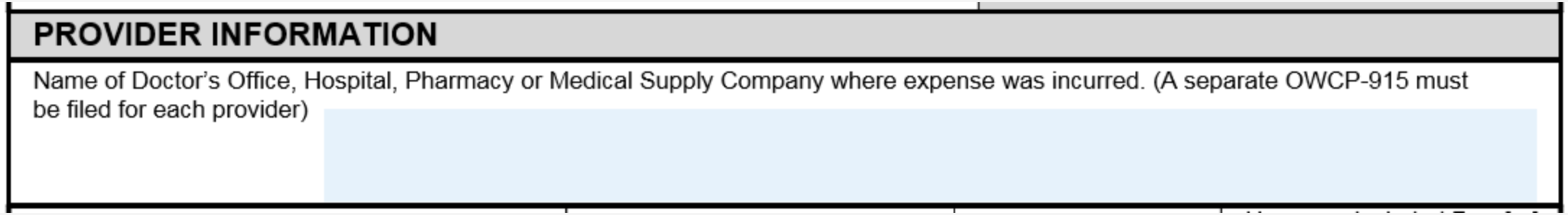
Telephone Number

FOR DOL USE ONLY

Completing the OWCP 915 Medical Reimbursement form

2 Please list the Provider/Organization name.

Note: Claimants must submit a separate form for each Provider where Medical Services were rendered.

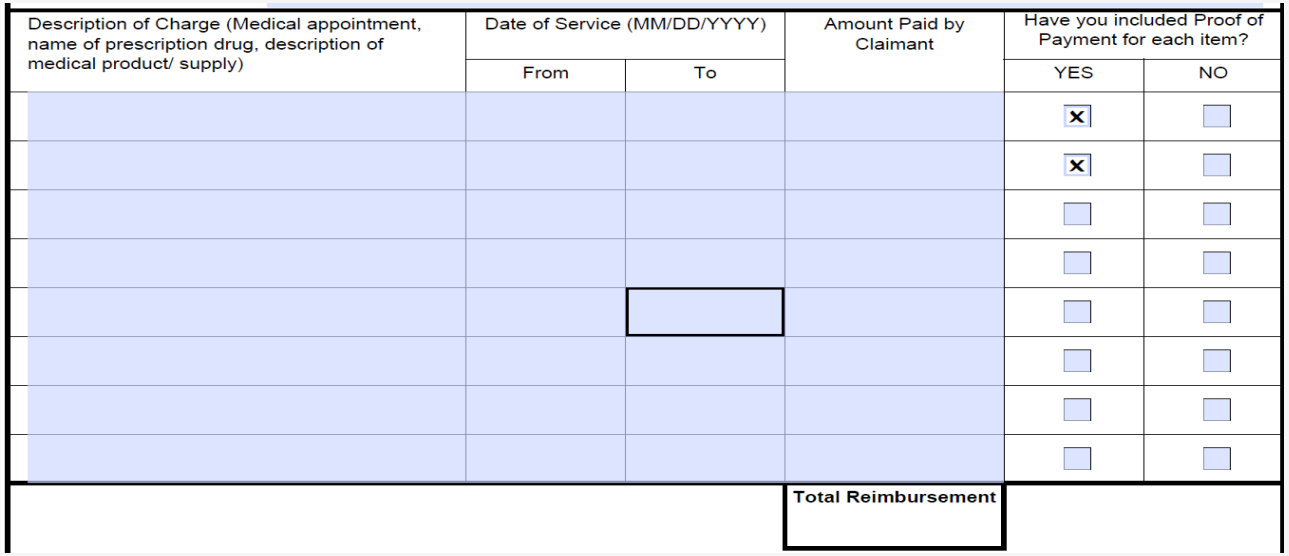


PROVIDER INFORMATION
Name of Doctor's Office, Hospital, Pharmacy or Medical Supply Company where expense was incurred. (A separate OWCP-915 must be filed for each provider)

Completing the OWCP 915 Medical Reimbursement form

3

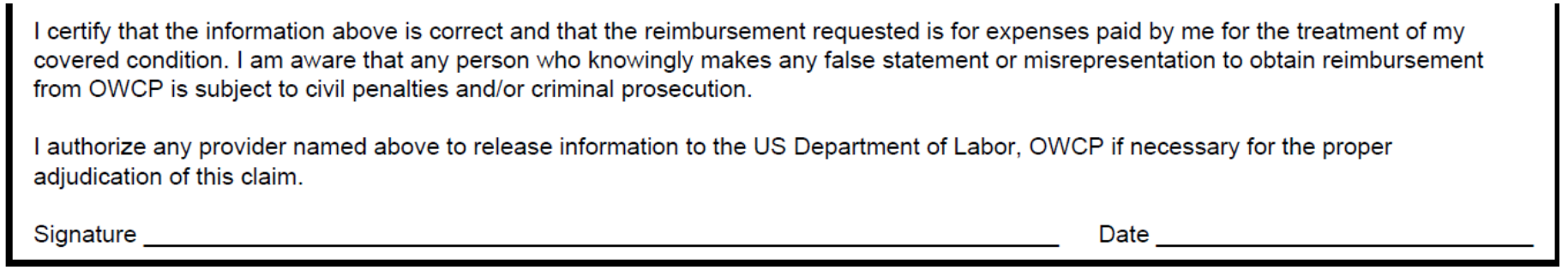
- List the description of charges
- Enter the Date of Service (MM/DD/YYYY) range
- Enter the Amount paid out of pocket by Claimant
- Select “YES” checkbox stating that you have included Proof of Payment
- Up to 8 visits and/or services can be listed on the form
- Calculate the Total Amount Paid for all visits and fill in the box at the bottom



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

Completing the OWCP 915 Medical Reimbursement form

Form must be signed by the Claimant



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

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

Signature _____ Date _____

4

Form must be signed by claimant or a representative

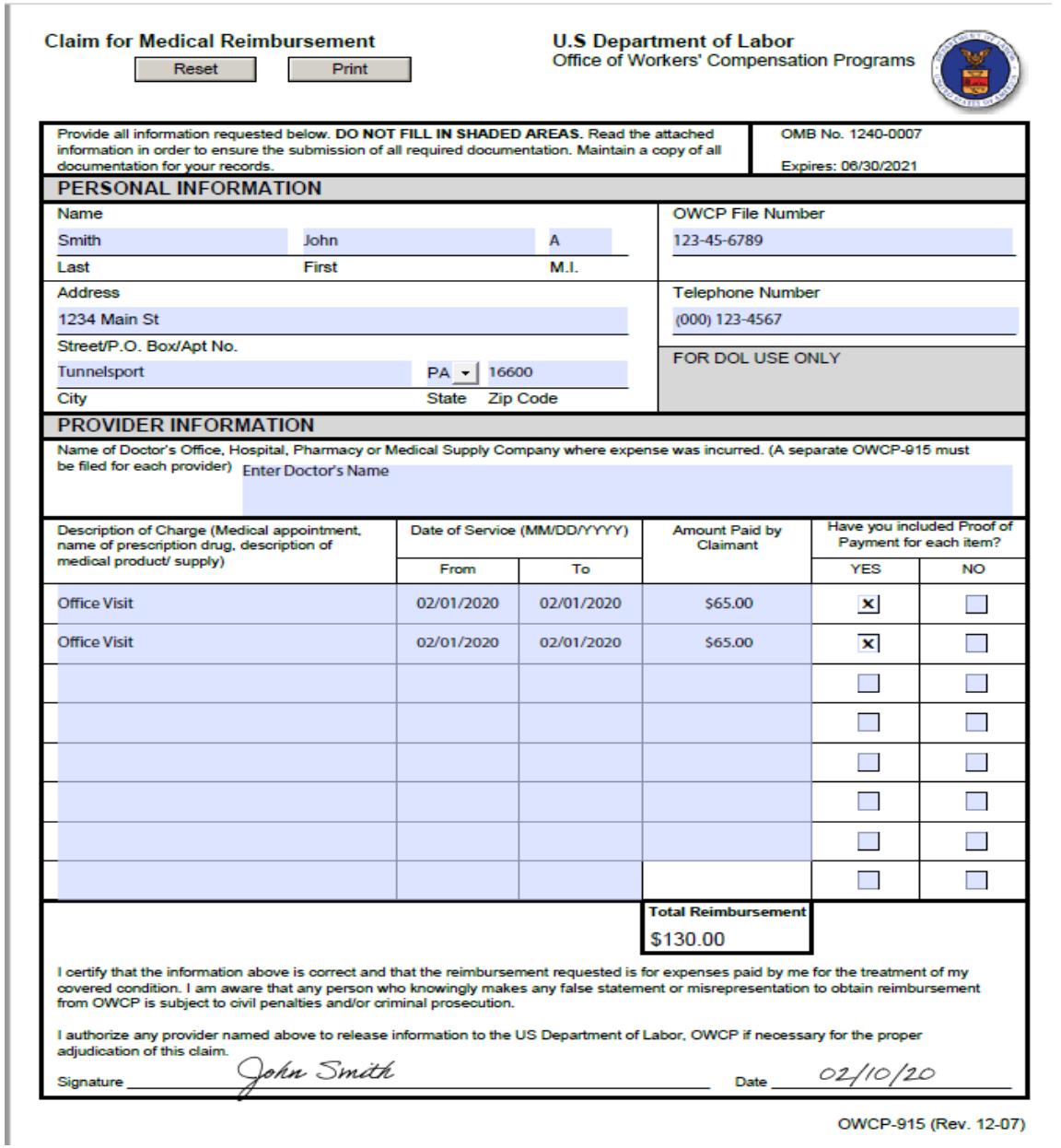
5

A date is required and must be on or after the last date of service listed on this form.

Completed 915 Form

1. Proof of payment is required (This can be a cash receipt, cancelled check or credit card slip)

2. It is recommended (but not required) to have your provider complete a HCFA 1500 form. This form can be submitted along with your 915 to ensure your bill is coded correctly and you are reimbursed for the proper services.



Claim for Medical Reimbursement

Reset Print

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

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

OMB No. 1240-0007
Expires: 06/30/2021

PERSONAL INFORMATION

Name: Smith (Last) | John (First) | A (M.I.)

OWCP File Number: 123-45-6789

Address: 1234 Main St (Street/P.O. Box/Apt No.)

Telephone Number: (000) 123-4567

Tunnelsport (City) | PA (State) | 16600 (Zip Code)

FOR DOL USE ONLY

PROVIDER INFORMATION

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

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM/DD/YYYY) From	Date of Service (MM/DD/YYYY) To	Amount Paid by Claimant	Have you included Proof of Payment for each item? YES	NO
Office Visit	02/01/2020	02/01/2020	$65.00	☒	☐
Office Visit	02/01/2020	02/01/2020	$65.00	☒	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Total Reimbursement $130.00

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

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

Signature: John Smith Date: 02/10/20

OWCP-915 (Rev. 12-07)

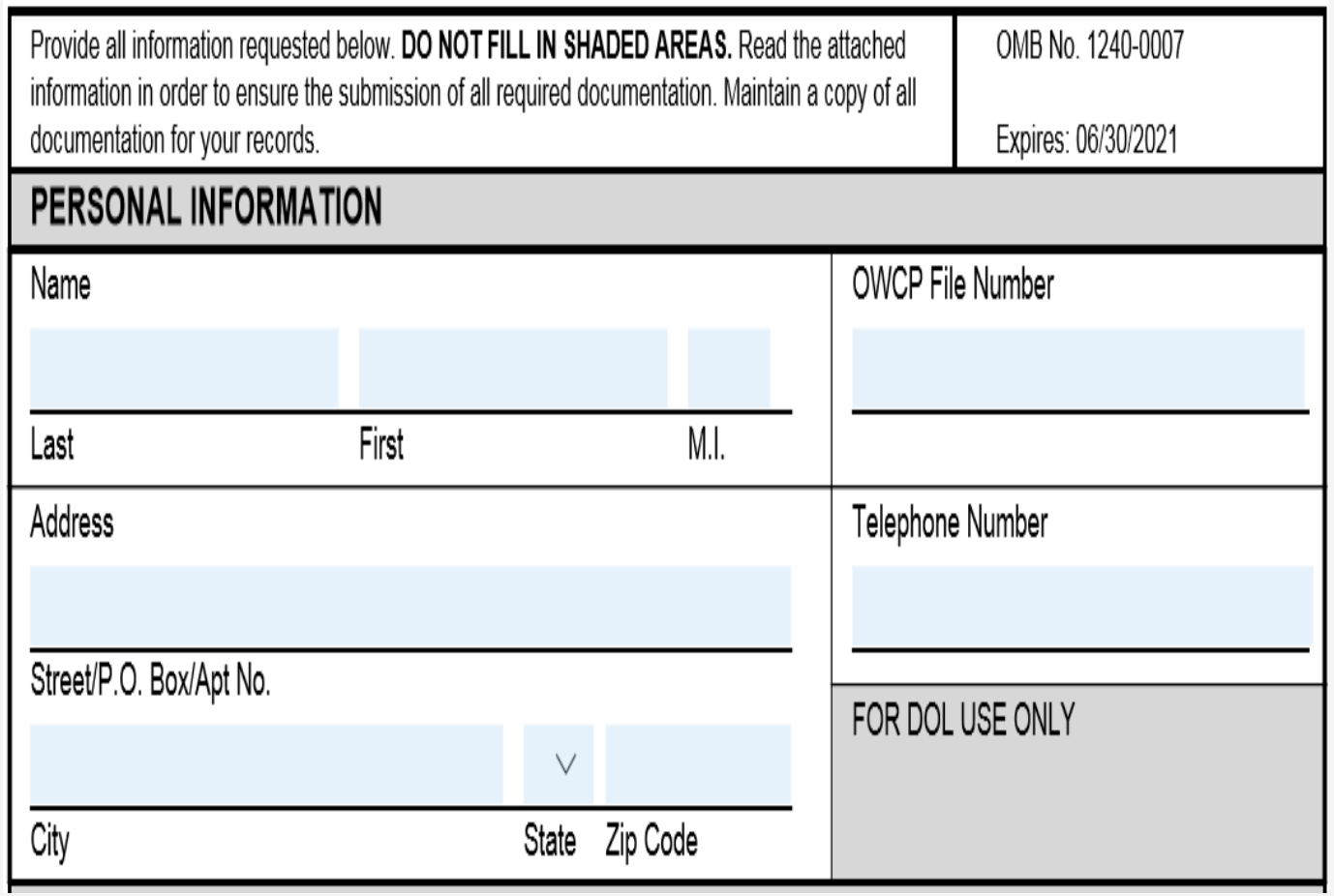
OWCP 915 Medical Reimbursement - Prescriptions

Completing the OWCP 915 Medical Reimbursement-Prescriptions Form

1

Enter your personal information

Note: Do not enter information in the gray shaded areas



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

OMB No. 1240-0007

Expires: 06/30/2021

PERSONAL INFORMATION

Name

Last First M.I.

OWCP File Number

Address

Street/P.O. Box/Apt No.

City State Zip Code

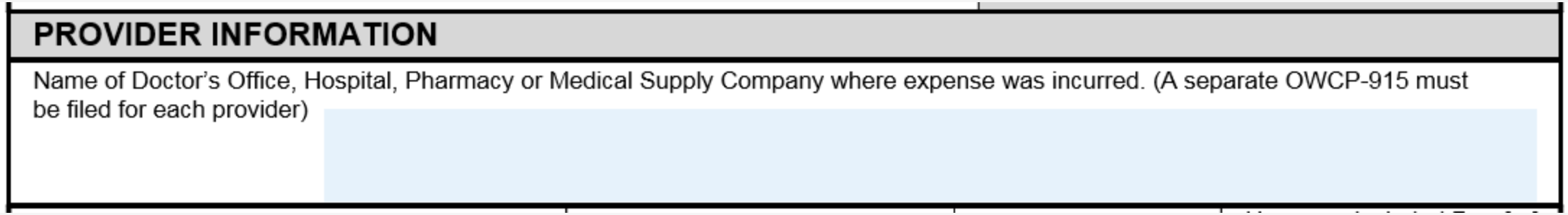
Telephone Number

FOR DOL USE ONLY

Completing the OWCP 915 Medical Reimbursement- Prescriptions Form

2 Please list the Pharmacy name

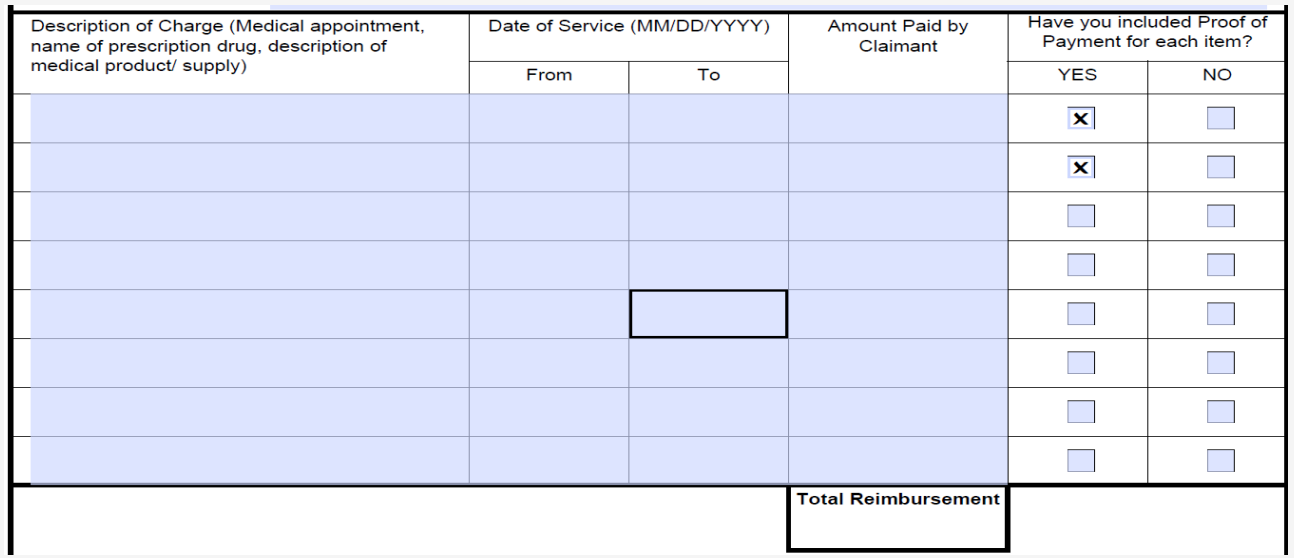
Note: A separate form is required for each Pharmacy where medications were dispensed.



Completing the OWCP 915 Medical Reimbursement form

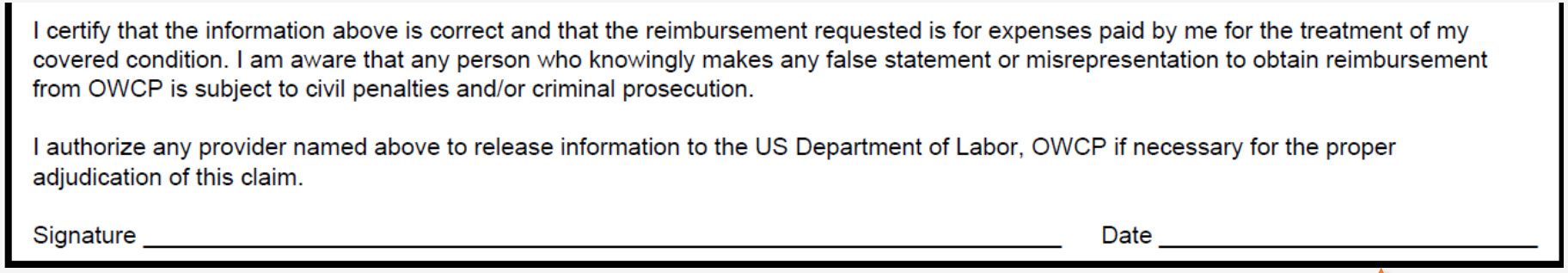
3

- List the National Drug Code #, the Quantity (how many ml/mg) and the days of supply under "Description of Charge"
- Enter the Date of Service (MM/DD/YYYY) when the prescription was filled
- Enter the Amount Paid by Claimant
- Select the "YES" checkbox stating that you have included proof of payment
- Up to 8 visits and/or services can be listed on this form
- Calculate the Total Amount Paid for all services and fill in the box at the bottom



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

Completing the OWCP 915 Medical Reimbursement form



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

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

Signature _____ Date _____

4

Form must be signed by claimant or a representative

5

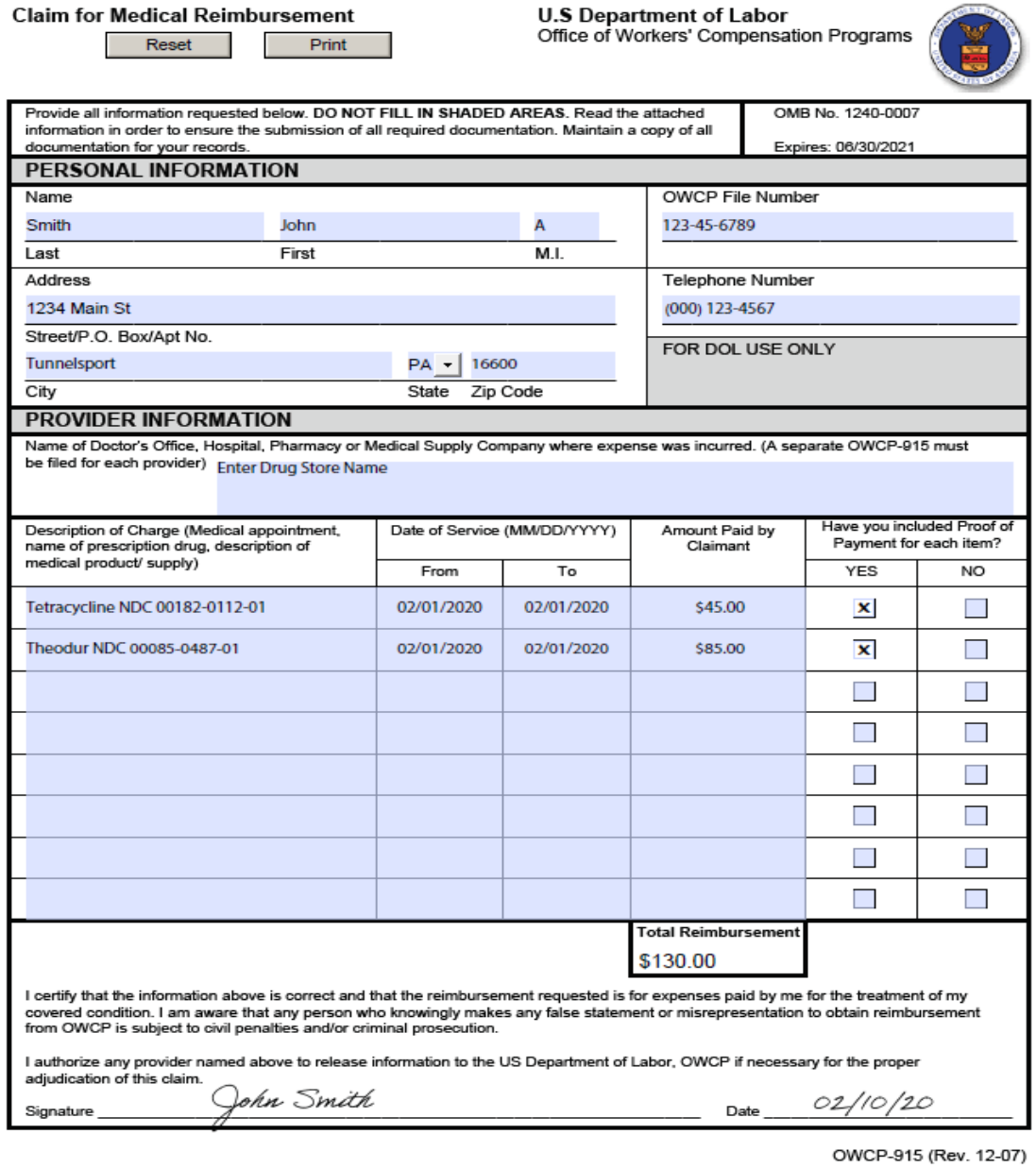
A date is required and must be on or after the last date of service listed on 915.

Completed 915 - Prescriptions Form

1. Proof of payment is required
(This can be a cash receipt, pharmacy itemized statement, cancelled check or credit card slip).

2. Receipts and pharmacy itemized statements must be marked "patient paid" or "paid by patient" to show who paid the charges

3. If pharmacy receipts have the NDC #, quantity and day of supply, the drug name can be listed on the 915 form.



Claim for Medical Reimbursement

Reset Print

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

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

OMB No. 1240-0007
Expires: 06/30/2021

PERSONAL INFORMATION

Name			OWCP File Number
Smith	John	A	123-45-6789
Last	First	M.I.	

Address	Telephone Number
1234 Main St	(000) 123-4567
Street/P.O. Box/Apt No.	
Tunnelsport PA 16600	FOR DOL USE ONLY
City State Zip Code	

PROVIDER INFORMATION

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

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM/DD/YYYY) From	To	Amount Paid by Claimant	Have you included Proof of Payment for each item? YES	NO
Tetracycline NDC 00182-0112-01	02/01/2020	02/01/2020	$45.00	X	
Theodur NDC 00085-0487-01	02/01/2020	02/01/2020	$85.00	X	

Total Reimbursement $130.00

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

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

Signature John Smith Date 02/10/20

OWCP-915 (Rev. 12-07)

OWCP 957A Travel Reimbursement-Mileage

This form is applicable to DFEC and DEEOIC programs.

Completing the OWCP 957A Travel Reimbursement Form – Mileage

1 Enter your personal information

NOTE: This report is authorized by the Federal Employees' Compensation Act (5 USC 8103(a)) and the Energy Employees Occupational Illness Compensation Program Act of 2000, (42 USC 7384 and 20 CFR 30.701). While you are not required to respond, this information is required to obtain reimbursement for mileage. The method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974, and OMB Circ. 130. This form should be used for medically related travel covered by the Federal Employees' Compensation Act and the Energy Employees Occupational Illness Compensation Program Act of 2000. For travel expenses reimbursement under the Black Lung Benefits Act (30 USC 901; 20 CFR 725.406 and 725.701) use the Form OWCP-957 Part B

OMB No. 1240-0037
Expires: 11/30/2026

1. Claimant Name (Last, First, M.I.):	2. Case/Claim Number:
3. Payee Name if different from claimant's name (Last, First, M.I.): (See Instruction No. 3 for further requirements if payee is not the claimant)	4. Claimant/Payee Phone No.:
5. Claimant/Payee Address (House #, Street or RR, City, State, Zip Code):	6. Claimant/Payee Email:

Completing the OWCP 957A Travel Reimbursement form – Mileage

2 Enter the following information:

a. In field **7a**, Enter the date or dates you traveled.

b. In field **7b**, select your reason for travel.

c. In field **7c**, select where you traveled from and to

d. In field **7d**, enter the full name and address of the medical facility.

e. In field **7e**, select if the trip was One-way or Round trip. Only select one box.

- **One-way**: Leaving to go to a destination without returning to the place you left.
- **Round trip**: Departing from your original location "A," traveling to your destination "B," and returning back to **"**A" (where you began).

f. In field **7f**, enter the total miles traveled for the trip.

7a. Date(s) of Travel	7b. Reason for Travel	7c. From (Full name and street address)	7d. To (Full name and street address)	7e. One-way /Round trip	7f. Total # Miles
	☐ Hospital ☐ Medical Appt. ☐ Therapy/Rehab ☐ Pharmacy ☐ Med. Supply ☐ Other			☐ One-way ☐ Round trip	

Completing the OWCP 957A Travel Reimbursement form – Mileage

Note: Sections cannot be partially completed. Use a new section for each Date of Service (DOS).

The person claiming reimbursement must sign and enter the date. The date must be on or after the last date of travel.

Payee Certification: I certify that the information provided is true and accurate to the best of my knowledge and belief. I am aware that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain reimbursement as provided by the OWCP, or who knowingly accepts reimbursement to which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for OWCP fraud will result in termination of all current and future OWCP benefits.

8. Claimant/Payee Signature: Date:

Form OWCP-957 Part A
November 2023

OWCP 957B Travel Reimbursement-Expenses

This form is applicable to all programs.

Completing the OWCP 957B Travel Reimbursement Form - Expenses

1. Enter your personal information.

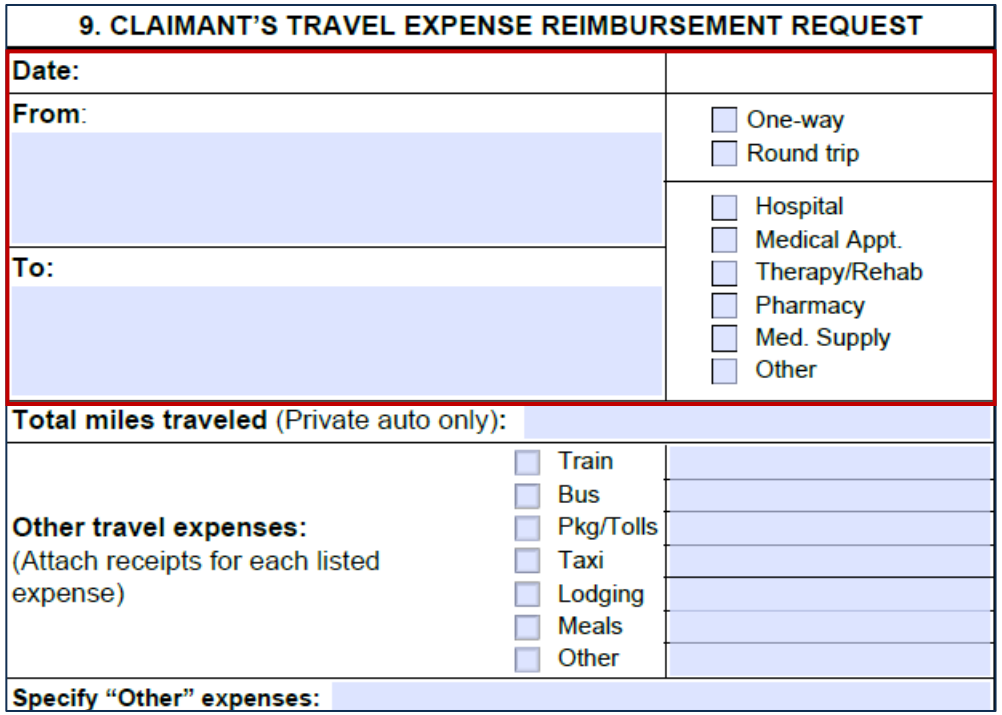
NOTE: This report is authorized by the Federal Employees' Compensation Act (5 USC 8103(a)), the Black Lung Benefits Act (30 USC 901; 20 CFR 725.406 and 725.701) and the Energy Employees Occupational Illness Compensation Program Act of 2000, (42 USC 7384 and 20 CFR 30.701). While you are not required to respond, this information is required to obtain reimbursement for travel expenses. The method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974, and OMB Circ. 130. This form should be used for medically related travel covered by the Federal Employees' Compensation Act, the Black Lung Benefits Act, and the Energy Employees Occupational Illness Compensation Program Act of 2000.

OMB No. 1240-0037
Expires: 11/30/2026

1. Claimant Name (Last, First, M.I.):	2. Case/Claim Number:
3. Payee Name if different from claimant's name (Last, First, M.I.):	4. Claimant/Payee Phone No.:
5. Claimant/Payee Address (House #, Street or RR, City, State, Zip Code):	6. Claimant/Payee Email:
7. Payee relationship to Claimant:	8. Reason Payee other than Claimant is requesting reimbursement:

Completing the OWCP 957B Travel Reimbursement Form - Expenses

9. Complete a separate block for each medical facility, pharmacy, therapist, etc. visited.
   a. In the **Date** field, enter the date of travel.
   b. In the **From** field, enter the full street address of the location where your trip began.
   c. In the **To** field, enter the full street address of the location where your trip ended.
   d. In the checkboxes to the right of **From** field, select the checkbox indicating whether the trip was **one-way** or **round trip**.



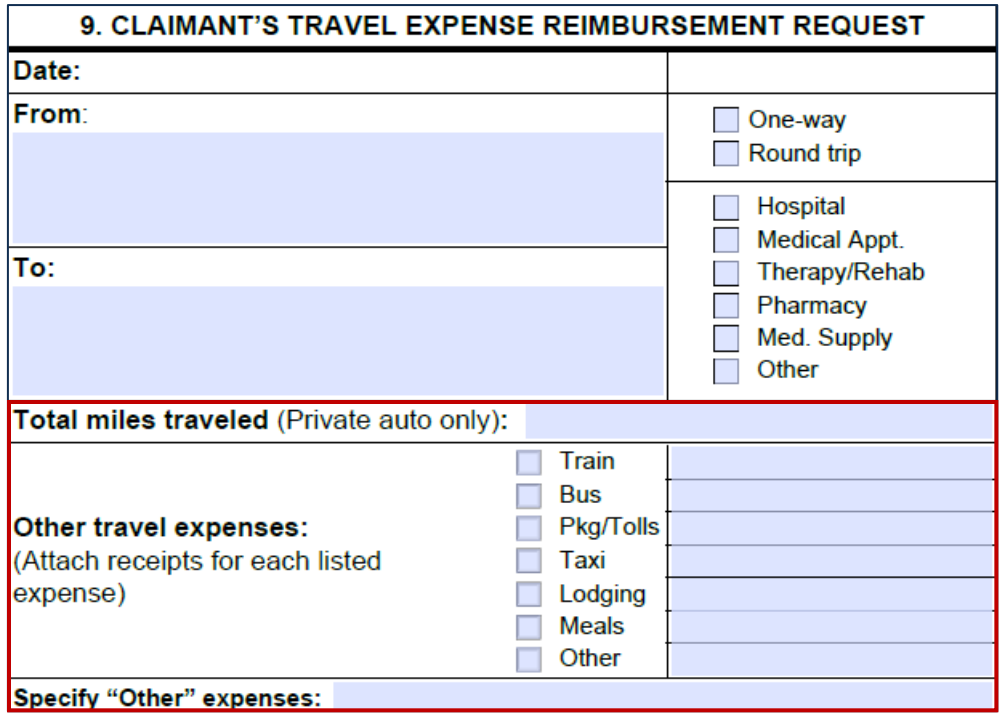
Completing the OWCP 957B Travel Reimbursement Form - Expenses

9. Complete a separate block for each medical facility, pharmacy, therapist, etc. visited.

   a. If you drove or were driven in a private car, in the **Total miles traveled** field, enter the number of miles here for mileage reimbursement.
   Note: Claimants are reimbursed per mile and not based on a gas receipt. Ensure your miles include only whole numbers and not decimals. (**Example:** If you traveled 9.2 miles, enter 9 miles.)

   b. In the **Other travel expenses** field, select the applicable checkboxes and enter the dollar amount spent in each category. Attach receipts for each item. If you use the "Other" checkbox, name the item in the line below the checkbox.

Note: If you use the "Other" checkbox, list the actual cost and specify the type of expense in the **Specify "Other" expenses** field.



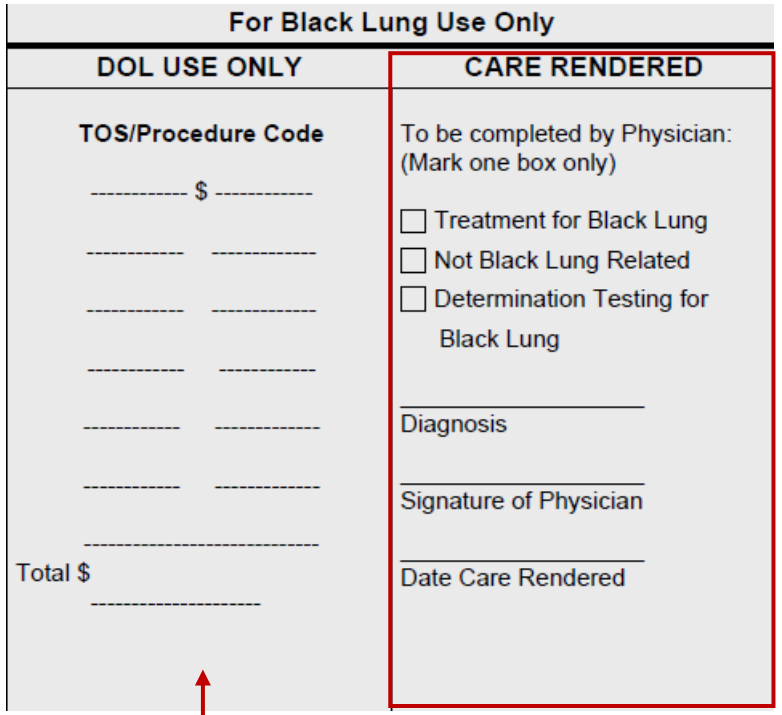
Completing the OWCP 957B Travel Reimbursement Form - Expenses

For **Black Lung Use Only**:

The Physician must complete this section. Only one checkbox can be selected to describe the reason for services rendered.

- Treatment for Black Lung
- Not Black Lung Related
- Determination Testing for Black Lung

The Physician must enter diagnosis details to represent what the treatment is for, then sign and date the form.



Do not complete this column. It is for DOL use only!!!

Completing the OWCP 957B Travel Reimbursement form - Expenses

Note: Sections cannot be partially completed. Use a new section for each Date of Service (DOS).

The person claiming reimbursement must sign and enter the date. The date must be on or after the last date of travel.

Payee's Certification: I certify that the information provided is true and accurate to the best of my knowledge and belief. I am aware that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain reimbursement as provided by the OWCP, or who knowingly accepts reimbursement to which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for OWCP fraud will result in termination of all current and future OWCP benefits.

10. Claimant's/Payee's Signature: Date:

Form OWCP-957 Part B
November 2023

Requirements for Reimbursement of the OWCP 957A and 957B Forms

Original receipts are required for lodging, airfare, rental car, and any other expense that exceeds $75.

Claimant's last name and OWCP Claim Number must be listed on submitted attachments. Be sure to keep a copy for your records.

Black Lung Claimants:

- Travel expenses for the miner are reimbursable
- Lodging or travel exceeding 100 miles one-way or 200 miles roundtrip requires prior authorization from the District Office
- Travel to pick up medicine, equipment, or supplies is not reimbursable

Energy Claimants:

- Lodging or travel exceeding 100 miles one-way or 200 miles roundtrip requires prior authorization from the District Office
- Reimbursement of companion travel requires prior authorization from the District Office

DFEC Claimants:

- Meals, lodging, and travel exceeding 100 miles roundtrip require prior authorization from the District Office

You are ready to submit your claim!

Claimant Reimbursements can be submitted via mail to:

1. **Division of Federal Employees' Compensation Act (FECA)**
   PO Box 8300 London, KY 40742-8300

2. **Division of Energy Employees Occupational Illness Compensation (DEEOIC)**
   PO Box 8304
   London, KY 40742-8304

3. **Division of Coal Mine Workers' Compensation (DCMWC)**
   PO Box 8302
   London, KY 40742-8302

Note: If your bill is not processed within 28 days, contact a Customer Service Specialist.

Thank you!

Acentra Health looks forward to being the new medical bill processing agent for the OWCP programs and working with each of you!

Email: CNSIOWCPOutreach@cns-inc.com

Call Center:

Division of Federal Employees' Compensation
(DFEC) 1-844-493-1966

Division of Energy Employees
Occupational Illness Compensation
(DEEOIC) 1-866-272-2682

Division of Coal Mine Workers' Compensation
(DCMWC) 1-800-638-7072