HOW TO SUBMIT OWCP- 1500 BILLS TO ACS

The services performed by the following types of provider should be billed on the OWCP-1500 Form:

◦**Physicians** (MD, DO)	◦**X-Ray**	◦**Independent Laboratories**
◦**Audiologists/Speech Pathologist**	◦**Hearing Aid Specialists**	◦**Therapists**
◦**Community Health Departments**	◦**DME**	◦**Visual Services**
◦**Chiropractors**	◦**Home Health**	◦**Prosthetics/Orthotics**
◦**Ambulatory Surgical Centers**	◦**Home Attendant Services**	◦**Rural Health Clinics**
◦**Ambulance**	◦**Psychologist**	◦**Podiatrist**

As a provider you have the option of sending your bills either electronically or by paper.

PAPER BILLS SHOULD BE SENT TO:

US Department of Labor
P O Box 8300
DFEC Central Mailroom
London, KY 40742-8300

ELECTRONIC BILL SUBMISSION

Submitting DOL bills via electronic media offers the advantage of speed in processing. Providers may submit electronic bills or choose a billing agent that offers electronic bill submission services. Billing agents must enroll as DOL providers.

The Electronic Data Interchange (EDI) Support Unit assists providers who have questions about electronic bill submission. ACS's EDI Support Unit is available to all providers Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Standard Time at 800-987-6717.

EDI Support will:

- Provide information on available services.
- Assist in enrolling users for electronic bill submission and report retrieval.
- Process test transmissions.
- Provide technical assistance on transmission difficulties.

AUTHORIZATION REQUIREMENTS

The FECA Program pays for medical services rendered for work-related injury or disease. Some services require prior authorization. Listed below are some of the services that require prior authorization:

◦**All inpatient admissions**	◦**All surgical procedures**
◦**MRIs and CT scans**	◦**Home health services**
◦**Some durable medical equipment**	◦**Anesthesia CPT codes 01995 and 01996**

◦**Physical therapy services - Physical therapy authorization requests must be accompanied by a physician's prescription and a treatment plan. Authorization will be given for the number of modalities to be done per day and the number of days requested.**

Routine services such as office/clinic visits, plain x-ray films and laboratory services do <u>NOT</u> require prior authorization.

Please call (866) 335-8319 or fax (800) 215-4901 to request an authorization.

BILLING REQUIREMENTS

1. **<u>All bills must contain the Federal Employees' Compensation (FECA) 9-digit case number of your patient or client.</u>**
2. Anesthesia services must be billed with the appropriate anesthesia CPT code (00100 – 01999).
3. Drugs dispensed at the physician's office, other than injections, require NDC.
4. Facility charges for ambulatory surgical center/outpatient surgery billing must be billed using the surgical CPT code. Please use the SG modifier in addition to the surgical CPT code.
5. When billing for services over a period of time, use the "From" and "Through" dates with the appropriate units for each CPT code billed.
6. Please refer to the attached OWCP-1500 list and the required fields for additional instructions.

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCH NAM

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURA AN N GR AME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR AL USE

TH AN ER LTH ER AN? S N re and iple

READ BACK OF FORM BEFORE A SIGNING THIS F

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE lease of dica nf tion sa to process this claim. I also request payment of governmen its e mys pa c assig below.

13. IN UT IZE RS URE pa ical b ts to und sician or plier for se described b

SIGNED DA S

14. D ENT: MM Y ILLNESS (F st mptom) OR INJURY OR REGNA P) F PA NT H AD E C MILAR ILLNE GIV M D YY

16. DAT NT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM DD YY TO MM DD YY

17. N OF REFERRI CIAN HER SOURC I.D BER OF REF ING

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. R VED OR AL U

20. OUTSIDE LAB? YES NO $ CHARGES

21. D R RE C NE OR INJURY. (RE ITEM 3 OR TO ITEM 24E BY LINE)

1. L . 3. L .

2. L . 4. L .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

OWCP –1500 CLAIM ITEM	TITLE	ACTION
1	**Medicare and Medicaid**	No entry required.
1a	**Insured's ID Number**	Enter the claimant's case number.
2	**Patient's Name**	Enter the claimant's last name, first name, and middle initial.
3	**Patient's Birth Date** **Patient's Sex**	Enter the claimant's date of birth in month, day, and year format. Use an "X" to mark the appropriate box, male or female.
4	**Insured's Name**	No entry required.
5	**Patient's Address**	Enter the claimant's address.
6	**Patient's Relationship to Insured**	No entry required.
7	**Insured's Address**	No entry required unless the claimant is covered by other insurance.
8	**Patient Status**	No entry required.
9a-d	**Other Health Insurance Coverage**	Enter the requested information if the claimant has other insurance. Enter the word "none" or "not applicable" if there is no other insurance coverage.
10a-c	**Is Patient's Condition Related to:**	Use an "X" to indicate the related condition.
10d	**Reserved for Local Use**	No entry is required.
11a-d	**Insured's Group No.**	No entry required.
12	**Patient's or Authorized Person's Signature**	Have the claimant sign the form. "Signature on file" is acceptable.
13	**Insured's or Authorized Person's Signature**	"Signature on file" required if payment is assigned to provider.

OWCP –1500 CLAIM ITEM	TITLE	ACTION
14	**Date of current illness, injury or pregnancy**	No entry required.
15	**Dates of Same or Similar Illness**	No entry required.
16	**Dates Patient Unable to Work**	No entry required.
17 and 17a	**Name of Referring Physician and DOL Provider ID Number**	No entry required.
18	**Hospitalization Dates Related to Current Services**	No entry required.
19	**Reserved for Local Use**	No entry required.
20	**Was Laboratory Work Performed Outside Your Office?**	No entry required.
21	**Diagnosis or Nature of Illness or Injury**	Enter the diagnosis code(s). At least one header diagnosis is required.
23	**Prior Authorization Number**	No entry required.
24 A	**Date(s) of Service**	Enter the beginning date of service (From Date) in month, day, and year format. Services rendered in one calendar month may be billed on one line with a "From Date" and a "To Date."
B	**Place of Service**	Enter the two-digit place of service (POS) code for each procedure performed.
C	**Type of Service**	No entry required.

OWCP –1500 CLAIM ITEM	TITLE	ACTION
D	**Procedures, Services or Supplies: CPT HCPCS codes and modifiers**	Enter the procedure code. Enter modifiers if appropriate.
E	**Diagnosis Code**	Enter a pointer to correspond to the diagnosis code in block 21. Do not enter the diagnosis codes on the line.
F	**Charges**	Enter the usual and customary charge for the procedure performed in dollars and cents format. The decimal must be included. For example: 250.00.
G	**Days or Units**	Enter the units of service rendered for each detail line. A unit of service is the number of times a procedure is performed. **Anesthesiologists**: Enter the anesthesia time in total minutes. For example, one hour and fifteen minutes should be entered as "75." **Do not convert time to units.**
H	**EPSDT (Child Health Check-Up) and Family Planning Indicator**	No entry required.
I	**EMG**	No entry required.
J	**COB**	No entry required.
K	**Reserved for Local Use**	No entry required.
25	**Federal Tax ID Number**	Enter the Federal Tax ID Number.
26	**Patient's Account Number**	The provider may enter a claimant account number so that it will appear on the remittance voucher.
27	**Accept Assignment**	No entry required.

OWCP –1500 CLAIM ITEM	ITEM	ACTION
28	**Total Charge**	Add together all charges in the column under #24F and enter the total amount in this item.
29	**Amount Paid**	Enter the amount paid by other health insurance coverage if applicable. This amount must equal the total of the entries in column 24K. The amount must be entered in dollar and cents format, including the decimal. For example: 250.00 Do **not** enter prior DOL payments here when filing an adjustment invoice.
30	**Balance Due**	No entry required.
31	**Signature of Physician or Supplier and Date**	Sign and date the bill form. Signature stamp is allowed. "Signature on file" may be used.
32	**Name and Address of Facility Where Services Were Rendered**	**Mandatory field.** Enter the complete name and address of hospital, facility or physician's office where services were rendered, including the zip code.
33	**Provider's Name, Address, Zip Code, Telephone Number and DOL Provider Number**	Enter the provider's name, address, zip code and telephone number in the upper portion of the item. **Enter the nine-digit DOL provider number in the lower portion of the field as found in your Welcome packet. If the provider is an individual provider, the provider number must be entered after the "PIN#." If the provider is a group provider, the group number must be entered after the "GRP#."** The provider number entered in item 33 is where DOL payment is made. It is also used to report DOL payments to the IRS.

Place of Service Codes (POS)

Code		Description
3		School
4		Homeless Shelter
5		Indian Health Service Free-Standing Facility
6		Indian Health Service Provider–Based Facility
7		Tribal 638 Free-Standing Facility
8		Tribal 638 Provider-Based Facility
11		Office
12		Patient Home
15		Mobile Unit
20		Urgent Care
21		Inpatient Hospital
22		Outpatient Hospital
23		Emergency Room-Hospital
24		Ambulatory Surgical Center
25		Birthing Center
26		Military Treatment Facility
31		Skilled Nursing Facility
32		Nursing Facility
33		Custodial Care Facility
34		Hospice
41		Ambulance-Land
42		Ambulance-Air or Water
50		Federally Qualified Health Center
51		Inpatient Psychiatric Facility
52		Psychiatric Facility Partial Hospitalization
53		Community Mental Health Center (CMHC)
54		Intermediate Care Facility/Mentally Retarded
55		Residential Substance Abuse Treatment Facility
56		Psychiatric Residential Treatment Center
60		Mass Immunization Center
61		Comprehensive Inpatient Rehabilitation Facility
62		Comprehensive Outpatient Rehabilitation Facility
65		End Stage Renal Disease Treatment Facility
71		State or Local Public Health Clinic
72		Rural Health Clinic
81		Independent Laboratory
99		Other Place of Service