

HOW TO SUBMIT OWCP-1500 BILLS TO ACS

OFFICE OF WORKERS' COMPENSATION PROGRAMS DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION

The services performed by the following providers 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

BILLS SHOULD BE SENT TO:

US Department of Labor
P O Box 8304
London, KY 40742-8304

ELECTRONIC REMITTANCE VOUCHER RETRIEVAL

Retrieving DOL remittance vouchers via electronic media offers the advantage of speed in retrieval. All providers, including pharmacies, may access reports online as well as receive paper copies of the remittance vouchers.

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 report retrieval.
- Provide technical assistance on retrieval difficulties.

AUTHORIZATION REQUIREMENTS

The DEEOIC program pays for medical services rendered for employees of the Department of Energy with radiation-related cancer and other illnesses related to radiation, Chronic Beryllium Disease, and Chronic Silicosis. 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 **NOT** require prior authorization.

[Please call \(866\) 272-2682](tel:8662722682) [or fax \(800\) 882-6147](tel:8008826147) [to request an authorization.](#)

To request an authorization via fax, use the appropriate template provided in this packet.

BILLING REQUIREMENTS

1. **All bills must contain the Division of Energy Employees Occupational Illness Compensation Program (DEEOIC) 9-digit case number of your patient or client and your 9-digit DEEOIC provider number.**
2. All professional services will be paid using the Fee Schedule established by OWCP. This Fee Schedule can be downloaded from http://www.dol.gov/esa/owcp_org.htm.
3. Anesthesia services must be billed with the appropriate anesthesia CPT code (00100 – 01999).
4. Drugs dispensed at the physician's office, other than injections, require NDC.
5. 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.
6. When billing for services over a period of time, use the "From" and "Through" dates with the appropriate units for each CPT code billed.
7. Please refer to the attached OWCP-1500 list and the required fields for additional instructions.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA	
1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)	CIAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)	FECA BLK LUNG <input type="checkbox"/> (SSN)	OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE			
ZIP CODE		TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		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) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO (State)		b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										SIGNED	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE				17b. NPI		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
1. _____ 3. _____						23. PRIOR AUTHORIZATION NUMBER					
2. _____ 4. _____						F. \$ CHARGES	G. DAYS OR UNITS	H. EPSTD Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> 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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()			
SIGNED				DATE				a. NPI		b. NPI	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

OWCP –1500 Claim Item	Title	Action	Required?
1	Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	No Entry Required.	N
1a	Insured's ID Number	Mandatory Field. Enter the claimant's case number.	Y
2	Patient's Name	Enter the claimant's last name, first name, and middle initial.	Y
3	Patient's Birth Date, Sex	Enter the claimant's 8-digit birth date (MM DD CCYY). Use an "X" to mark the appropriate box for patient sex.	Y
4	Insured's Name	Enter the claimant's last name, first name, and middle initial.	Y
5	Patient's Address	Enter the claimant's address and telephone number.	Y
6	Patient's Relationship to claimant	No Entry Required.	N
7	Insured's Address	No Entry required unless the claimant is covered by other insurance.	N
8	Patient Status	No Entry Required.	N
9a-d	Other Insured's Name	If Item Number 11d is marked, complete fields 9 and 9a-d, otherwise leave blank.	N
9a	Other Insured's Policy or Group Number	Enter the policy or group number of the claimant.	N
9b	Other Insured's Date of Birth, Sex	Enter the 8-digit date of birth (MM DD CCYY) of the other claimant and an X to indicate the sex of the other claimant. Only one box can be marked. If gender is unknown, leave blank.	N
9c	Employer's Name or School Name	Enter the name of the other claimant's employer or school.	N
9d	Insurance Plan Name or Program Name	Enter the claimant's insurance plan or program name.	N
10a-c	Is Patient's Condition Related to:	When appropriate, enter an X in the correct box.	N
10d	Reserved for Local Use	No Entry Required.	N

11	Insured's Policy, Group, or FECA Number	Enter the claimant's policy or group number as it appears on the claimant's health care identification card. If Item Number 4 is completed, then this field should be completed.	N
11a	Insured's Date of Birth, Sex	Enter the 8-digit date of birth (MM DD CCYY) of the claimant and an X to indicate the sex of the claimant.	N
11b	Insured's Employer's Name or School Name	Enter the name of the claimant's employer or school.	N
11c	Insurance Plan Name or Program Name	Enter the insurance plan or program name of the claimant.	N
11d	Is there another Health Benefit Plan?	When appropriate, enter an X in the correct box. If marked "YES", complete 9 and 9a-d.	N
12	Patient's or Authorized Person's Signature	Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6 digit format (MMDDYY) or 8-digit format (MMDDCCYY). If there is no signature on file, leave blank or enter "No Signature on File."	Y
13	Insured's or Authorized Person's Signature	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."	Y
14	Date of current illness, injury or pregnancy	No Entry Required.	N
15	If Patient Has Had Same or Similar Illness	No Entry Required.	N
16	Dates Patient Unable to Work in Current Occupation	No Entry Required.	N
17	Name of Referring Provider or Other Source	Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered, or supervised the service(s) or supply(s) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider	N
17 a	Other ID#	The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.	N
17 b	NPI #	Enter the NPI number of the referring, ordering, or supervising provider.	N

18	Hospitalization Dates Related to Current Services	No Entry Required.	N
19	Reserved for Local Use	No Entry Required.	N
20	Outside Lab? \$Charges	Complete this field when billing for purchased services.	N
21	Diagnosis or Nature of Illness or Injury	Enter the diagnosis/condition. List up to four ICD-9-CM diagnosis codes.	Y
22	Medicaid Resubmission Code	No Entry Required.	N
23	Prior Authorization Number	Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service. (Optional)	N
24a	Date(s) of Service	Mandatory Field. Enter the beginning date of service in month, day, year format. Services rendered in one calendar month may be billed on one line with a "From Date" and a "To Date."	Y
24b	Place of Service	Mandatory Field. Enter the two-digit place of service (POS) code for each procedure performed.	Y
24c	EMG	No Entry Required.	N
24d	Procedures, Services, or Supplies	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service.	Y
24e	Diagnosis Pointer	Enter the diagnosis code reference number (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis.	Y
24f	\$ Charges	Enter number right justified in the dollar area of the field. Do not use commas. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.	Y
24g	Days or Units	Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.	Y
24h	EPSDT/Family Plan	No Entry Required.	N
24i	ID Qualifier	Enter in the shaded area of 24i the qualifier identifying if the number is a non-NPI.	N

24j	Rendering Provider ID #	Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.	N
25	Federal Tax ID Number	Enter the provider of service or supplier federal tax ID (employer identification number) or Social Security number. Enter an X in the appropriate box to indicate which number is being reported.	Y
26	Patient's Account No.	Enter the patient's account number assigned by the provider of services or supplier's accounting system.	N
27	Accept Assignment	No Entry Required.	N
28	Total Charge	Enter total charges for the services (i.e., total of all charges in 24f).	Y
29	Amount Paid	Enter total amount the patient or other payers paid on the covered services only. Enter number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.	N
30	Balance Due	Enter total amount due.	N
31	Signature of Physician or Supplier Including Degrees or Credentials Bill Date	Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit or 8 digit date, or alphanumeric date (e.g., January 1, 2003) that the form was signed.	Y
32	Service Facility Location Information	Enter the name, address, city, state, and zip code of the location where the services were rendered.	Y
32 a	NPI#	Enter the NPI number of the service facility location in 32a.	N
32 b	Other ID#	Enter the two digit qualifier identifying the non-NPI number followed by the ID number.	N
33	Billing Provider Info & Ph #	Enter the provider's or supplier's billing name, address, zip code, and phone number.	Y
33 a	NPI#	Enter the NPI number of the billing provider.	N
33 b	Other ID#	ACS Provider Number is required <i>You may also see a two digit qualifier identifying the non-NPI number followed by the ID number.</i>	Y

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	Birth 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



**Durable Medical Equipment
Authorization Request Form**
Please fax with supporting medical documentation
800-882-6147



Effective January 3, 2005 all Prior Authorization requests must be submitted through the Web Bill Processing Portal (<http://owcp.dol.acs-inc.com>), Medical Authorization Entry screen or faxed using the available template. Requests that are not properly coded with CPT or HCPCS codes cannot be processed.

Date Requested _____ Requested by _____

Case file # _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

ACS Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

Procedure Code(s) and/or Modifier(s) (CPT, HCPCS) _____

Rental or Purchase and price per item _____

Duration Requested _____

Comments _____

**Please remember to send prescription from attending physician and any supporting
medical documentation for request.**

800-882-6147



**General Medical, Hospital, Radiology and Surgery
Authorization Request Form**
**Please fax with supporting medical documentation
800-882-6147**



Effective January 3, 2005 all Prior Authorization requests must be submitted through the Web Bill Processing Portal (<http://owcp.dol.acs-inc.com>), Medical Authorization Entry screen or faxed using the available template. Requests that are not properly coded with CPT or HCPCS codes cannot be processed.

Date Requested _____ Requested by _____

Case file # _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

ACS Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

ICD-9 _____

Procedure Code(s) and/or Modifier(s) (CPT, HCPCS, RCC) _____

Specific body part to be treated _____

Units/Days Requested _____

Is this a second surgery on the same body part? _____

Comments _____

**Please remember to send any supporting medical documentation with request.
Please put Case File # on every page faxed.
800-882-6147**



PT and OT Authorization Request Form
Please fax with supporting medical documentation
800-882-6147



Effective January 3, 2005 all Prior Authorization requests must be submitted through the Web Bill Processing Portal (<http://owcp.dol.acs-inc.com>), Medical Authorization Entry screen or faxed using the available template. Requests that are not properly coded with CPT or HCPCS codes cannot be processed.

Date Requested _____ Requested by _____

Case file # _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

ACS Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

ICD-9 _____

Procedure Code(s) and/or Modifier(s) (CPT, HCPCS) _____

Specific body part to be treated _____

Frequency and Duration Requested _____

Comments _____

Please remember to send prescription from attending physician and treatment plan with request for physical therapy or occupational therapy. Please put Case File # on every page faxed.

800-882-6147