HOW TO SUBMIT OWCP - 1500 BILLS TO ACS

The services performed by the following providers should be billed on the OWCP-1500 Form:

•**Physicians** (MD, DO)	•**Radiologists**	•**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**
•Some Injections	**•Home health services**
•Some durable medical equipment	**•Anesthesia CPT codes 01995 and 01996**
•Physical/Occupational therapy services – Physical/ Occupational 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, diagnostic tests, and laboratory services do <u>NOT</u> require prior authorization.

Please call (850) 558-1818, fax (800) 215-4901 using the attached authorization forms, or access our website ***owcp.dol.acs-inc.com*** 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, as well as, the 9 digit ACS Provider Number.</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 along with the quantity and strength.
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.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) 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 ☐ F ☐

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

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ 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? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT 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

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. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

SAMPLE

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 un-shaded 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** *You may also see a two digit qualifier identifying the non-NPI number followed by the ID number.*	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		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 Rental Disease Treatment Facility
71		State or Local Public Health Clinic
72		Rural Health Clinic
81		Independent Laboratory
99		Other Place of Service

General Medical and Surgery
Authorization Request Form
Please fax with supporting medical documentation.
Fax # (800) 215-4901

Effective January 3, 2005, all Prior Authorization requests must either be faxed on this template or be submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal (http:\\owcp.dol.acs-inc.com). **All fields are required and must be complete. Incomplete requests and requests that are not properly coded with CPT or HCPCS cannot be processed and will be returned.**

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 _____

Comments _____

_____

_____

Please remember to send any supporting medical documentation with request. Please put Case File # on every page faxed.
Fax # (800) 215-4901

Durable Medical Equipment
Authorization Request Form
Please fax with supporting medical documentation.
Fax # (800) 215-4901

Effective January 3, 2005, all Prior Authorization requests must either be faxed on this template or be submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal (http:\\owcp.dol.acs-inc.com). **All fields are required and must be complete. Incomplete requests and requests that are not properly coded with CPT or HCPCS cannot be processed and will be returned.**

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, RCC) _____

_____

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

Fax # (800) 215-4901

Physical Therapy/Occupational Therapy
Authorization Request Form
Please fax with supporting medical documentation.
Fax # (800) 215-4901

Effective January 3, 2005, all Prior Authorization requests must either be faxed on this template or be submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal (http:\\owcp.dol.acs-inc.com). **All fields are required and must be complete. Incomplete requests and requests that are not properly coded with CPT or HCPCS cannot be processed and will be returned.**

Date Requested _____ Requested by _____

Case file # _____ Claimant's Name_____

Claimant Date of Birth _____ Claimant's DOI _____

Provider Name _____

ACS Provider Number _____

Provider Tax ID _____

ICD-9 Diagnoses Code _____

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

_____

Specific body part to be treated _____
Right___, Left_____, Bilateral___, N/A_____

Treatment Schedule:
Date(s) of Service Requested _____
No. of units per day: _____
No. of days of therapy per week_____ **No. of Weeks**_____
Total Units Req. (no. of units per day x no. of therapy days x No of weeks = total units)
_____

Treatment Plan (include long/short term goals)
_____

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.
Fax # (800) 215-4901