HEALTH INSURANCE (NALC) CLAIM FORM

CARRIER REIMBURSEMENT

Instructions: This form should only be used by Providers Enrolled with OWCP under Provider Type 95 (Third Party Carriers)
Note that omission of OWCP File Number (ITEM 3) will result in delays in bill processing; and the Procedure Code must be entered in item 6.C, using the appropriate code from the Physician's Current Procedural Terminology, 4th Edition (CPT 4). Do not use other codes. In addition, the Diagnosis Code (Item 6.D) must be entered for each separate diagnosis listed in item 5, using the coding structure of the International Classification of Diseases, Clinical Modification, 9th Edition (ICD 9 CM).

1. PATIENT'S NAME (*First name, middle initial, last name*)	3. OWCP FILE NO. *(Date of illness or injury)*
2. PATIENT'S ADDRESS (*Street, City, State, ZIP code)*	4. CARRIERS NAME, ADDRESS (*Street, City, State, ZIP*) EIN NUMBER: TELEPHONE NUMBER:

5. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (*Relate diagnosis to procedure in column D by reference numbers 1, 2, 3 etc.*)

1.

2.

3.

4.

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 CODE *(IDENTIFY)*	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F CARRIER PAYMENT	G CARRIER'S PAYEE
				TOTAL CHARGE:		AMOUNT PAID:	

7. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. ACS PROVIDER NUMBER:_____	8. SIGNATURE OF CARRIER'S REPRESENATIVE (I certify that the above documentation is reflected in the carriers official files) SIGNED: _____ DATE:_____	9. PHOTOCOPIES: YES NO BILLS ☐ ☐ CANCELLED CHECKS ☐ ☐