# HOW TO SUBMIT OWCP-1500 BILLS TO CONDUENT

**OFFICE OF WORKERS' COMPENSATION PROGRAMS**
**DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL ILNESS 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. Conduent'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:

| | |
|---|---|
| ◦**Psychiatric Treatment** | ◦**Acupuncture Treatments** |
| °**Chiropractic Services** | °**Home Health Services** |
| °**Durable Medical Equipment** | °**Organ Transplant (Including Stem Cell)** |
| °**Experimental Treatment** | °**Clinical Research** |
| °**Hospice Care** | °**Extended Care Facilities** |
| °**Vehicle/Housing Modifications** | °**Massage Therapy** |

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

Please call (866) 272-2682 or fax (800) 882-6147 to request an authorization.

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

## BILLING REQUIREMENTS

1. **<u>All bills must contain the Division of Energy Employees Occupational Illness Compensation Program (DEEOIC) 9 digit case identification number of your patient or client and your 9-digit DEEOIC provider number.</u>**

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/owcp/regs/feeschedule/fee.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.

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE

PATIENT AND INSURED INFORMATION

| | | |
|---|---|---|
| 1. ☐ MEDICARE (Medicare#) ☐ MEDICAID (Medicaid#) ☐ TRICARE (ID#/DoD#) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (ID#) ☐ FECA BLK LUNG (ID#) ☐ OTHER (ID#) | | 1a. INSURED I.D. NUMBER (For Program in Item 1) |
| 2. PATIENT'S NAME (Last, First, Middle Initial) | 3. PATIENT'S BIRTH DATE SEX M F | 4. INSURED'S NAME (Last, First, Middle Initial) |
| 5. PATIENT'S ADDRESS (Street, City, State, Zip) TELEPHONE (Include Area Code) | 6. PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other 8. RESERVED FOR NUCC USE | 7. INSURED'S ADDRESS (Street, City, State, Zip) TELEPHONE (Include Area Code) |
| 9. OTHER INSURED'S NAME (Last, First, Middle Initial) | 10. PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR FECA NUMBER |
| a. OTHER INSURED POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) Yes No | a. INSURED'S DATE OF BIRTH SEX M F |
| b. RESERVED FOR NUCC USE | b. AUTO ACCIDENT? PLACE (State) Yes No | b. OTHER CLAIM ID (Designated by NUCC) |
| c. RESERVED FOR NUCC USE | c. OTHER ACCIDENT? Yes No | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| d. PATIENT'S PLAN OR PROGRAM NAME | 10d. CLAIM CODES (Designated by NUCC) | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? Yes No If yes, complete items 9, 9a, and 9d. |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM<br>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.<br>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.<br>SIGNED |

PHYSICIAN OR SUPPLIER INFORMATION

| | | |
|---|---|---|
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL. | 15. OTHER DATE QUAL. | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM: TO: |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. 17b. NPI | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: TO: |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? Yes No $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L. | | 22. RESUBMISSION CODE ORIGINAL REF. NO.<br>23. PRIOR AUTHORIZATION NUMBER |

| 24. A. DATE(S) OF SERVICE From | To | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER (A-L) | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID QUAL | J. RENDERING PROVIDER NPI # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |
| | | | | | | | | | | 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. Rsvd for NUCC Use |
|---|---|---|---|---|---|
| | | | | | |

| 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.)<br>SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION<br>a. b. | 33. BILLING PROVIDER INFO & PH #<br>a. b. |
|---|---|---|

| 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**<br><br>**Sex** | Enter the claimant's 8-digit birth date (MM \| DD \| CCYY).<br>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**<br><br>**Telephone Number** | Enter the claimant's address.<br><br>Enter the claimant's telephone number. | Y |
| 6 | **Patient's Relationship to claimant** | No Entry Required. | N |
| 7 | **Insured's Address, Telephone Number** | No Entry required unless the claimant is covered by other insurance. | N |
| 8 | **Reserved For NUCC Use** | 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 | **Reserved For NUCC Use** | No Entry Required | N |
| 9c | **Reserved For NUCC Use** | No Entry Required | 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** | **Claim Codes (Designated By NUCC)** | 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**<br><br>**Sex** | Enter the 8-digit date of birth (MM \| DD \| CCYY) of the claimant.<br>Enter 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** | **Other Date, Qualifier** | 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 | N |

| | | | |
|---|---|---|---|
| | | Provider | |
| **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** | **Additional Claim Information (Designated by NUCC)** | 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**<br><br>**ICD Ind** | Enter the diagnosis/condition. List up to 12 ICD-10-CM diagnosis codes. Enter '9' if using ICD9 codes. Enter '0' if using ICD10 codes. | Y |
| **22** | **Resubmission Code, Original Ref No** | 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.<br><br>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** | **Rsvd For NUCC Use** | No Entry Required | N |
| **31** | **Signature of Physician or Supplier Including Degrees or Credentials** | Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or | Y |

| | | | |
|---|---|---|---|
| | **Bill Date** | "SOF." Enter either the 6-digit or 8 digit date, or alphanumeric date (e.g., January 1, 2003) that the form was signed. | |
| **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#** | Conduent **Provider Number** is required.*You may also use 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 |
| 9 | | Prison/Correctional Facility |
| 11 | | Office |
| 12 | | Patient Home |
| 13 | | Assisted Living Facility |
| 14 | | Group Home |
| 15 | | Mobile Unit |
| 16 | | Temporary Lodging |
| 17 | | Walk-in Retail Health Clinic |
| 18 | | Place of Employment – Worksite |
| 19 | | Off Campus Outpatient Hospital |
| 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 |
| 49 | | Independent Clinic |
| 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 |

| | | |
|---|---|---|
| **57** | | **Non-residential Substance Abuse Treatment Facility** |
| **60** | | **Mass Immunization Center** |
| **61** | | **Comprehensive Inpatient Rehabilitation Facility** |
| **62** | | **Comprehensive Outpatient Rehabilitation Facility** |
| **65** | | **End Stage Rental Disease Treatment Facility** |
| **71** | | **Public Health Clinic** |
| **72** | | **Rural Health Clinic** |
| **81** | | **Independent Laboratory** |
| **99** | | **Other Place of Service** |

**DURABLE MEDICAL EQUIPMENT(DME)/MEDICAL SUPPLY**

**PRIOR AUTHORIZATION REQUEST**

Please fax with supporting medical documentation to 800-882-6147.

REQUIRED DOCUMENTATION:

☐ DOCUMENTATION OF MEDICAL NECESSITY FROM THE TREATING PHYSICIAN

☐ A COPY OF THE SIGNED PRESCRIPTION

CLAIMANT FILE NUMBER: _____

CLAIMANT NAME: _____

DATE OF REQUEST: _____ CONTACT PERSON: _____

PROVIDER NAME: _____

PROVIDER NUMBER: _____ PROVIDER TAX ID: _____

PROVIDER ADDRESS: _____

PROVIDER FAX: _____ PROVIDER TELEPHONE: _____

ICD-9 DIAGNOSIS CODE(S)**(for dates of service 09/30/15 and prior):** _____

ICD-10 DIAGNOSIS CODES(S)**(for dates of service 10/1/15 and after):** _____

TREATING PHYSICIAN NAME: _____

Please indicate the cost for each item requested.

| **ITEM REQUESTED** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **DESCRIPTON** | **HCPCS/CPT CODE** | **MODIFIER** | **UNITS** | **PURCHASE** | **RENTAL** | **COST** | **DURATION OF NEED** | |
| | | | | | | | **START DATE** | **END DATE** |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

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

Effective January 3, 2005 all Prior Authorization requests must either be faxed on this template or submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal (https:\\owcpmed.dol.gov).All fields are required and must be complete.Incomplete requests cannot be processed and will be returned.

Date Requested _____ Requested by _____

Case file # _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

Conduent Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

ICD-9 Diagnosis Code(s)**(for dates of service 09/30/15 and prior)**_____

ICD-10 Diagnosis Code(s)**(for dates of service 10/01/15 and after)**_____

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 _____

_____

**Remember to send any supporting medical documentation with request.**
**Please put Case File # on every page faxed.**

## Physical Therapy, Occupational Therapy and Speech Therapy Request Form

Please fax with supporting medical documentation to 800-882-6147.

Effective January 3, 2005 all Prior Authorization requests must either be faxed on this template or submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal (https://owcpmed.dol.gov). All fields are required and must be complete. Incomplete requests cannot be processed and will be returned.

☐ New Request ☐ Amended Request

Date Requested _____ Requested by _____

Case file # _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

Conduent Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

ICD-9 Diagnosis Code(s)**(for dates of service 09/30/15 and prior)**_____

ICD-10 Diagnosis Code(s)**(for dates of service 10/01/15 and after)**_____

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

_____

Specific body part to be treated_____ _____

Frequency and Duration Requested _____

Comments _____

_____

**The prescription from the attending physician and treatment plan must be attached. Please include the claimant's case file number on every page submitted.**

**DEEOIC Home Health**
**Authorization Request**

**Please ensure the prescription signed by the physician and the Case/Subscriber Number is included with this authorization request.**

**Please submit fax to 1-800-882-6147.**

☐ New Request ☐ Amended Request

Date Requested _____ Requested by _____

Case/Subscriber Number _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

Conduent Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

ICD-9 Diagnosis Code(s)**(for dates of service 09/30/15 and prior)** _____

ICD-10 Diagnosis Code(s)**(for dates of service 10/01/15 and after)** _____

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

- ☐ T1001 frequency_____ duration_____ total units _____
- ☐ T1017 frequency _____ duration _____ total units _____
- ☐ T1019 frequency _____ duration _____ total units _____
- ☐ T1020 frequency _____ duration _____ total units _____
- ☐ T1030 frequency _____ duration _____ total units _____
- ☐ T1031 frequency _____ duration _____ total units _____
- ☐ S5126 frequency _____ duration _____ total units _____
- ☐ S9122 frequency _____ duration _____ total units _____
- ☐ S9123 frequency _____ duration _____ total units _____
- ☐ S9124 frequency _____ duration _____ total units _____
- ☐ S9126 frequency _____ duration _____ total units _____

**All supporting documentation must be faxed to 1-800-882-6147.**
**Please ensure the Case/Subscriber Number is included on every faxed page.**