Claimant Medical Reimbursement Form

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

NOTE: This report is authorized by law. Disclosure of your Social Security Number is voluntary. Failure to disclose this number will not result in the denial of any right, benefit or priviledge to which you may be entitled. This method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir.No. 108. This form is only to be used for requesting reimbursement of medical expenses payable under the Federal Employees' Compensation Act (FECA).

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1. Claimant's Name (Last, First, MI)	2. Claimant's Social Security Number (Optional)
3. Claimant's OWCP Case File Number	4. Claimant's Telephone Number

5. Claimant's Address (Number and Street/RFD, City, State, ZIP Code)

SPECIAL INSTRUCTIONS:

1. See reverse side of form for COMPLETE INSTRUCTIONS AND REQUIREMENTS FOR ATTACHMENT OF BILLS/RECEIPTS.
2. Please list below only charges that you paid related to medical services covered under the Federal Employees' Compensation Program.
3. Use a separate line for each type of service.

6. Name of Provider Making the Charge (Doctor, Hospital, Pharmacy, etc.)	Description of Charge (name of prescription drug, office visit, durable med. equipment e.g., back brace, TENS unit, etc.)	Date of Service or Purchase (Month, day, year, if there is only one date, show it under "From")		Amount Paid by Claimant	FOR DOL USE ONLY
		From	To		

Total amount paid by Claimant:

I certify that the information above is correct and that reimbursement requested is for expenses paid by me for treatment of my work-related condition. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain compensation under the FECA is subject to criminal prosecution and may be punished by a fine of not more than $10,000 or imprisonment for not more than five years,or both.

I authorize any provider named above to release information to the Office of Workers' Compensation Programs, Division of Federal Employees' Compensation if necessary for the proper adjudication of this claim.

Payee's Signature: _____ Date: _____

MAIL THIS COMPLETED FORM WITH ITEMIZED BILLS AND RECEIPTS SECURELY ATTACHED TO YOUR SERVICING OWCP/DFEC OFFICE.

INSTRUCTIONS FOR USE OF FORM CA-915

USE OF THIS FORM: This form is used to seek reimbursement for medical expenses (other than travel) incurred in the treatment of the condition(s) accepted by OWCP as work-related under the Federal Employees' Compensation Act.

INFORMATION REQUIRED FOR REIMBURSEMENT OF MEDICAL EXPENSES:

1. **Pharmacy drugs:**

Pharmacy must complete the Universal Drug Claim Form or equivalent, which must be attached to this form (CA-915) and must include the following:

Pharmacy's name, address and tax identification number (I.R.S. No.).
Claimant's name, address and OWCP claim number.
Name of physician who prescribed the drug(s).
Eleven digit National Drug Code (NDC).
Date filled.
Name of drug and strength.
Quantity (amount prescribed, expressed as the total number of tablets/capsules dispensed per prescription or total ml or cc per prescription for liquids).
New prescription or refill number.
Amount actually paid by claimant.

2. **Medical expenses other than pharmacy drugs.**

Physicians and other health care providers (i.e. physical therapists) must complete Form OWCP-1500. Hospitals and other facilities, such as ambulatory surgical centers, skilled nursing facilities, etc. must submit their bills on Form UB-92. Every form must be completed in its entirety in the same manner as bills submitted by the provider directly to OWCP. The amount actually paid by the claimant must be included. The Form OWCP-1500 or UB-92 must be attached to this Form (CA-915).

3. **Travel.**

Claims for travel reimbursement should be submitted on SF-1012, "Travel Voucher," not on Form CA-915. Instructions for submitting travel vouchers are found in Instruction CA-77.

4. **Proof of payment requirements.**

The following information is required as evidence that the claimant paid all or a portion of the bill:

- an itemized bill from the provider containing the information listed above, the original signature of the provider, and the amount paid by the claimant, or
- the provider's official receipt signed by the provider, indicating date(s) and specific services(s) rendered and the amount paid by the claimant.

Public Burden Statement

We estimate that it will take an average of 10 minutes to complete this collection of information, including time for reviewing instructions, searching for existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of the Labor, Office of Workers' Compensation Programs, Room S3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.