BILLS *OUTSIDE* THE UNITED STATES

- All bills for treatment received outside the U. S. are processed in the Cleveland District Office, Special Claims Unit.
- The Office can pay the provider directly (except in Germany)
- The unpaid bill should clearly indicate the medical provider's name and address
- We cannot deposit funds into foreign banks
- If the bill is in a foreign language, it is helpful if a translation could be provided.

BILLS *OUTSIDE* THE UNITED STATES

- To claim reimbursement of bills the employee has paid, submit an OWCP-915
- Make sure that a full and correct mailing address is provided
- Proof of payment and corresponding medical evidence must be provided
- Indicate the currency you wish to be reimbursed.

BILLS *OUTSIDE* THE UNITED STATES

- For reimbursement of medical expenses, direct deposit is available only if the bank is in the United States, and has a U.S. routing number and account number.
- Form SF 1199 must be submitted with each reimbursement form (OWCP-915)

ADDRESS FOR BILLS FOR TREATMENT OUTSIDE THE U.S.

U. S. DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMPENSATION
1240 E. 9TH STREET ROOM 839
ATTN: DAVID WOODS
DO NOT OPEN IN MAILROOM
CLEVELAND, OH 44199

Fax number to submit foreign medical bills:

216-357-5464

Claim for Medical Reimbursement

Reset Print

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

Provide all information requested below. **DO NOT FILL IN SHADED AREAS.** Read the attached information in order to ensure the submission of all required documentation. Maintain a copy of all documentation for your records.

OMB No. 1215-0193
Expires: 03/31/2010

PERSONAL INFORMATION

Name

Last First M.I.

OWCP File Number

Address

Street/P.O. Box/Apt No.

City State Zip Code

Telephone Number

FOR DOL USE ONLY

PROVIDER INFORMATION

Name of Doctor's Office, Hospital, Pharmacy or Medical Supply Company where expense was incurred. (A separate OWCP-915 must be filed for each provider)

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM, DD, YY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO

Total Reimbursement
$

I certify that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered condition. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain reimbursement from OWCP is subject to civil penalties and/or criminal prosecution.

I authorize any provider named above to release information to the US Department of Labor, OWCP if necessary for the proper adjudication of this claim.

Signature _____ Date _____

Medical Travel Refund Request

Reset Print

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

NOTE: This report is authorized by the Federal Employees' Compensation Act (5 USC 8103(a)), the Black Lung Benefits Act (30 USC 901; 20 CFR 725.406 and 725.701) and the Energy Employees Occupational Illness Compensation Program Act of 2000, (42 USC 7384 and 20 CFR 30.701). While you are not required to respond, this information is required to obtain reimbursement for travel expenses. The method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974 and OMB Circ. 108. This form should be used for medically related travel covered by the Federal Employees' Compensation Act, the Black Lung Benefits Act and the Energy Employees Occupational Illness Compensation Program Act of 2000.

OMB No. 1215-0054
Expires: 08/31/2010

1. Claimant's Name (Last, First, Mi.):

2. Case/Claim Number:

3. Payee's Name if different from claimant's name (last, first, mi.): (See instruction no. 3 on the back of form)

4. Claimant's/Payee's Address (Street/RFD, City, State, Zip Code):

Special Instructions:
1. See reverse side of form for complete instructions and attachment of receipts.
2. Physician's signature or facsimile is **REQUIRED by BLACK LUNG** for verification of each service date and type.

5a. Date of Travel:

b. ☐ One-way ☐ Round Trip

c. Travel From: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

d. Travel To: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

e. Medical facility name and address

f. Total expense/cost
☐ Taxi $
☐ Bus/Train
☐ Tolls/Pkg
☐ Lodging
☐ Meals
☐ Other
(Specify)

g. Private Auto Only Miles traveled

DOL USE ONLY
TOS/Procedure Code $
Total $

FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only)
Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
☐ Determine, Test for Black Lung
Diagnosis
(Signature of Physician)
(Date Care Rendered)

6a. Date of Travel:

b. ☐ One-way ☐ Round Trip

c. Travel From: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

d. Travel To: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

e. Medical facility name and address

f. Total expense/cost
☐ Taxi $
☐ Bus/Train
☐ Tolls/Pkg
☐ Lodging
☐ Meals
☐ Other
(Specify)

g. Private Auto Only Miles traveled

DOL USE ONLY
TOS/Procedure Code $
Total $

FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only)
Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
☐ Determine, Test for Black Lung
Diagnosis
(Signature of Physician)
(Date Care Rendered)

7a. Date of Travel:

b. ☐ One-way ☐ Round Trip

c. Travel From: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

d. Travel To: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

e. Medical facility name and address

f. Total expense/cost
☐ Taxi $
☐ Bus/Train
☐ Tolls/Pkg
☐ Lodging
☐ Meals
☐ Other
(Specify)

9. Private Auto Only Miles traveled

DOL USE ONLY
TOS/Procedure Code $
Total $

FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only)
Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
☐ Determine, Test for Black Lung
Diagnosis
(Signature of Physician)
(Date Care Rendered)

8. **Payee's Certification:** I hereby certify that the information given by me on and in connection with this form is true and correct to the best of my knowledge and belief. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain reimbursement from OWCP is subject to civil penalties and/or criminal prosecution.

Claimant's/Payee's Signature:

Date:

Form OWCP-957
Rev. Aug 2003