Claim for Medical Reimbursement Under Energy Employees Occupational Illness Compensation Program Act

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.:
Expires:

PERSONAL INFORMATION

Name

Last First M.I.

EEOICPA Case 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 EE-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 illness or disease. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain compensation under the EEOICPA 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 ______________

Form EE-915
May 2001

CLAIM FOR MEDICAL REIMBURSEMENT

- Under EEOICPA, you are eligible to seek reimbursement for out of pocket medical expenses pertaining to the treatment of an accepted covered illness or disease. The EE-915 form can be used to seek reimbursement for expenses in regard to medical treatment, prescription medication and medical supplies.
- Please submit a separate reimbursement claim for each provider where an out of pocket expense was incurred.
- Please print clearly and legibly. Reference your EEOICPA claim file number on all documentation submitted to the District Office. Maintain a copy of the completed EE-915 form and supporting documentation for your records.

DOCUMENTATION REQUIRED FOR MEDICAL REIMBURSEMENT

Prescription Medication

1. Completed EE-915
2. A Universal Health Claim form (NCPDP Form 79-1A) or equivalent, which must be attached to the EE-915 and must include the following information:
   a. Name, address and telephone number of pharmacy
   b. Tax identification number for pharmacy
   c. Name of doctor issuing prescription
   d. Name of medication
   e. Date of purchase
   f. Eleven Digit National Drug Code (NDC#)
   g. New prescription or refill number
   h. Quantity of medication (e.g. # of pills or ml/cc)
   i. Amount paid by employee per medication
3. Proof of payment indicating that the employee or authorized payee rendered payment for the claimed charges (Proof of payment can include cash receipt, cancelled check or credit card slip)

Medical Expense for Treatment of Accepted EEOICPA Condition (Other than prescription medication)

1. Completed EE-915
2. Physicians and other health care providers (i.e. physical therapists) must complete form HCFA 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 the EEOICPA. The amount paid by the claimant must be indicated. The HCFA-1500 or UB-92 must be attached to this form. It is the responsibility of the person submitting a claim for reimbursement to obtain a completed HCFA-1500 or UB-92 from the provider rendering service. *Without a fully completed HCFA-1500 or UB-92, the OWCP is not able to process a reimbursement.*
3. Proof of payment indicating that the employee or authorized payee rendered payment for the claimed charges (Proof of payment can include cash receipt, cancelled check or credit card slip)

Travel

Do not use form EE-915 to submit a claim for travel reimbursement. Claims for travel reimbursement should be submitted on SF-1012, "Travel Voucher."

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gather and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, sent them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim form to this address. Completed claims are to be submitted to the appropriate regional District Office of Workers' Compensation Programs. Persons are not required to respond to this information collection unless it displays a currently valid OMB number.

Form EE-915
May 2001

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