Claimant Medical Reimbursement Form

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

OMB No.: 1215-0193
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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 privilege 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) (20 CFR 10.802).

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		
	CLMMT				99
	CLMMT				99
	CLMMT				99
	CLMMT				99
	VREDU				99
	CLMMT				99
	CLMMT				99
	CLMMT				99

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.