

Supervisor Workers' Compensation Claim Checklist

Employee's Name

Date of Injury/Illness

DOL Claim Number:

ECN Number (ECOMP):

Reporting the Injury; Medical Documentation

Supervisor issues CA-16, Authorization for (Emergency-immediate) Examination if needed. (Only issued within the first week, only 1 form can be issued-CONTACT ABC-C if needed)

Supervisor informed employee Medical documentation must be provided to support all lost time.

Employee Reported Injury Hard Copy using Form CA-1 or CA-2.

Supervisor received Injury claim via ECOMP- Completed Review/Digitally Signed within 2 business days.

Supervisor received Injury claim via ECOMP- Returned to Employee for Errors_____ (Date).

Supervisor received Injury claim Hard Copy- Completed Review/Signed form within 2 business days.

Supervisor contacted Army Benefits Center- Injury Compensation Branch- Agency Reviewer (Specialist).

Agency Reviewer (ICS) forwarded CA-1 or CA-2 for hard copy signatures, Supervisor and employee signed form, returned copy immediately through email AND mailed original via USPS (required to be maintained at the ABC-C location).

Supervisor completes the Suspicious Claim Form and returns to the Agency Reviewer (ICS).

Employee uses Form CA-17 or CA-20 for follow up medical appointments- signature for Duty Status must be a Physician. Note: Inform Physician the Agency has light duty available.

Supervisor forwards medical documentation to the ABC-C Agency Reviewer (ICS).

COP; Timecard

Supervisor informed employee of their 45 day entitlement to COP for CA-1 claim (if applicable) (refer to Supervisor Responsibility Letter) (Medical must be provided within 10 days to Supervisor or COP can be denied.)

Supervisor ensured timecard was coded LU for the date of the injury.

Supervisor ensured timecard was coded LT for the 45 days of authorized COP.

Supervisor ensured timecard was coded KD for LWOP after the initial 45 days of authorized COP.

Supervisor submits an RPA for LWOP- OWCP after 80 hours of lost time.

Supervisor ensured timecard was corrected upon denial of claim: LS, LA or LWOP-KA.

Supervisor forwards the Initial and Subsequent Form CA-7's and Initial SF-1199 Direct Deposit Form to Agency Reviewer within 1 business day of receipt.

Medical Bills and Reimbursement Information

Medical Provider

Must have ACS Provider Number to be receive payment from the DOL/OWCP

Must submit bills using <http://owcp.dol.acs-inc.com>

Physician must sign the claimants CA-17, CA-20 and all other Medical restrictions notices. (cannot be a PA or Nurse)

Claimant

Must provide Supervisor with updated work status information provided by Physician

Must hard copy mail the HCFA1500- American Medical Association Standard Health Insurance Claim Form or UB 92- Hospital Charges Claim Form to Department of Labor, PO Box 8300, London, KY 40742-8300

Must submit claim OWCP Form 915- Medical reimbursement for any medical payments ie. co-pay, prescriptions, visit.

Must submit claim OWCP Form 957- Medical Travel Refund Request to be reimbursed for travel (as applicable) to Supervisor who will forward to the Agency Reviewer (ICS).

Agency Reviewer: ICS Information

Agency Reviewer Name:

Agency Reviewer Email Address

ABC-C Mailing Address:

ABC-C Injury Compensation Branch 6
305 Marshall Ave
Fort Riley, KS 66442

ABC-C Centralized Phone/Fax

Phone: 1-866-792-7620- Option # 1
Fax: 1-785-239-1489