TDI Division of Workers' Compensation

Submit to:
Workers' Compensation Insurance Carrier listed in Section IV of this form

REQUEST FOR REIMBURSEMENT OF PAYMENT MADE BY HEALTH CARE INSURER

I. DATE AND TYPE OF REQUEST

1. Date of Request	2. Check ONLY one box to indicate the Texas Labor Code Section(s) that apply to this request: a. ☐ §409.009 b. ☐ §409.0091 c. ☐ both §409.009 and §409.0091

If b. or c. is checked in Box 2 above, provide the following information:[1]

3. TDI-DWC Data Match Date (mm/dd/yyyy)	4. TDI-DWC Data Match File Name

II. HEALTH CARE INSURER INFORMATION

5. Health Care Insurer Name	6. Federal Employer ID Number	7. Address (Street or PO Box, City State Zip)	
8. Point of Contact Name	9. Point of Contact Phone Number	10. Point of Contact Fax Number	11. Point of Contact E-mail Address

III. HEALTH CARE INSURER ASSIGNEE OR AUTHORIZED REPRESENTATIVE INFORMATION (if applicable)

12. Assignee/Authorized Representative Name	13. Federal Employer ID Number	14. Address (Street or PO Box, City State Zip)	
15. Point of Contact Name	16. Point of Contact Phone Number	17. Point of Contact Fax Number	18. Point of Contact E-mail Address

IV. WORKERS' COMPENSATION INSURANCE CARRIER INFORMATION

19. Workers' Compensation Insurance Carrier Name		20. Address (Street or PO Box, City State Zip)	
21. Point of Contact Name (if known)	22. Point of Contact Phone Number	23. Point of Contact Fax Number	24. Point of Contact E-mail Address

V. WORKERS' COMPENSATION CLAIM INFORMATION

25. Patient / Injured Employee Name	26. TDI-DWC Claim Number	27. Date of Injury	28. Patient / Injured Employee SSN

Note: With few exceptions, on your request, you are entitled to:

- be informed about the information DWC collects about you;
- receive and review the information (Government Code Sections 552.021 and 552.023); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or refer to the Corrections Procedure section at www.tdi.texas.gov/commissioner/legal/lccorprc.html.

VI. HEALTH CARE SERVICE INFORMATION

Provide the required information in the table below or by attaching documents such as explanations of benefits, medical bills, or other automated reports that contain the required information.

Provider Name	Provider FEIN	Provider NPI[2]	Date of Service[3]	Place of Service	Diagnosis Code	Procedure Code[4]	Unit(s)[5]	Amount Charged by Provider	Amount Paid by Health Care Insurer
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
								$	$
							TOTALS	$	$

[1] Tex. Lab. Code §409.0091(n) and §409.0091(s) require a data match as described by §402.084 (c-3) in order to establish timeliness of a request for reimbursement by the health care insurer. The TDI-DWC Data Match File Name will conform to the naming convention listed for Claim Data Request Files in Addendum B of the Health Plan Claim Matching EDI Implementation Guide (PDF). Guide found at https://www.tdi.texas.gov/wc/edi/index.html#hpcmatch.

[2] Optional

[3] Provide date of service for each specific service/line item.

[4] Procedure codes include:

- CPT or HCPCS Code, and Modifier if applicable, for professional services
- National Drug Code (NDC) for pharmacy services
- Revenue Code, and HCPCPS Code and Modifier if applicable, for hospital services
- Dental codes for dental services

[5] Provide number of units for each specific service/line item (if applicable).