Texas Department Of Insurance
Division of Workers' Compensation
Records Processing
7551 Metro Center Dr. Ste.100 • MS-94
Austin, TX 78744-1609
(800) 252-7031 (512) 804-4378 fax www.tdi.state.tx.us

Submit this form to the Workers' Compensation Insurance Carrier listed in Section III of this form.

REIMBURSEMENT REQUEST FOR PAYMENT MADE BY HEALTH CARE INSURER (DWC Form-026)

Section I Health Care Insurer Information

Health Care Insurer Name	Federal Employer Identification Number	Address (Street, City, State, Zip Code)	
Point of Contact Name	Point of Contact Phone Number	Point of Contact Fax Number	Point of Contact E-mail Address

Section II Health Care Insurer Assignee or Authorized Representative Information

Assignee or Authorized Representative Name	Federal Employer Identification Number	Address (Street, City, State, Zip Code)	
Point of Contact Name	Point of Contact Phone Number	Point of Contact Fax Number	Point of Contact E-mail Address

Section III Workers' Compensation Insurance Carrier Information

Workers Compensation Insurer Name		Address (Street, City, State, Zip Code)	
Point of Contact Name (if known)	Point of Contact Phone Number	Point of Contact Fax Number	Point of Contact E-mail Address

Section IV Workers' Compensation Claim Information

Patient or Injured Employee Name	Division Claim Number	Patient or Injured Employee SSN: (last four digits only) xxx-xx-	Date of Injury

Section V Health Care Service Information – Use additional sheets as required, or provide required data below by attaching automated reports

Provider Name	Provider FEIN	Date of Service	Place of Service	ICD-9 Code	Procedure*	Units (if applicable)	Amount Charged	Amount Paid by Health Care Insurer
						Total Dollar Amount		

* CPT or HCPCS, and modifiers if applicable; NDC, Revenue Code, or Dental Code

Instructions for Completing the Reimbursement Request Made by a Health Care Insurer Form (DWC Form-026)

This form shall be submitted to the Workers' Compensation Insurance Carrier.
Do not submit the form to the Texas Department of Insurance, Division of Workers' Compensation (TDI/DWC).

Section I Health Care Insurer Information
Provide the Health Care Insurer name (HCI), Federal Employer Identification Number (FEIN), address and point of contact name information.

Section II Health Care Insurer Assignee or Authorized Representative Information
Complete Section II if an entity other than the HCI submits the reimbursement request form. For example, the HCI has assigned reimbursement rights to another entity or the form is submitted by an authorized representative.

Provide the Health Care Insurer Assignee or Authorized Representative name, FEIN, address and point of contact name information.

Section III Workers' Compensation Insurance Carrier Information
Provide the name and address of the Workers' Compensation Insurance Carrier to which the reimbursement request is being submitted. Provide Workers' Compensation Insurance Carrier point of contact information, if known.

Section IV Workers' Compensation Claim Information
Provide the name of the patient/injured employee, the patient's/injured employee's Social Security Number, the TDI/DWC-assigned claim number, and the date of injury.

Section V Health Care Service Information
Provide information related to the health care services for the patient/injured employee listed in Section IV and paid for by the HCI. Additional sheets or automated reports may be attached as necessary. Provide the full name, credentials, and FEIN of the health care provider, and billing information for the health care services including:

- Date(s) of Service(s) for each specific service/line item
- Place of Service (POS)
- ICD-9 Diagnosis Code(s)
- Procedure Code, including:
    - 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.
- Number of units for each specific service/line item (if applicable).
- Amount charged by the health care provider to the HCI.
- Amount paid to the health care provider by the HCI.
- Total amount charged and paid.

NOTE: With few exceptions, you are entitled, on request, to be informed about the information that the Division collects or maintains about you and your workers' compensation claim. Under §552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under §559.004 of the Texas Government Code you are entitled to have the Division correct information the Division creates about you or your workers' compensation claim that is incorrect. For more information, call the local Division Field Office at 1-800-252-7031.