

Contract Claims Services Inc.

"Going the extra mile to meet the needs of our Clients"

To access the online forms, go to: www.contract-claims.com. Enter your Username and Password and select Log In.



CCSI CONTRACT CLAIMS SERVICES, INC.

[Home](#) [About Us](#) [Services](#) [Ancillary Services](#) [Medicare Set-Aside](#) [MSA Referral Form](#) [Links](#) [Contacts](#) [Careers](#)

Log On

Username:

Password:

[Forgot Your Password?](#)

Claims Operations
P.O. Box 541388
Dallas, TX 75354
800.743.2231 **Phone**
972.786.7349 **Fax**



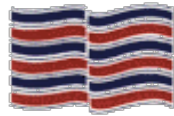
Welcome

Welcome to the Contract Claims Services, Inc. website. Whether you are a current client or just browsing, we are glad you stopped by. If you are a current client, please sign in and take advantage of the many services available to you.

CCSI is a privately held, employee-owned company located in Dallas, TX. We are the leading third party administrator (TPA) for federal workers' compensation in

News & Updates

- DOL posts 2013 OWCP medical fee schedule. There are significant changes in fee schedule reimbursement for some services such as an MRI of the knee. The reimbursement for an MRI of the knee was reduced over 35% in the 2013 fee schedule. Anyone managing longshore claims or with longshore claims exposure should confirm their bill auditor is now using the updated fee schedule.



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For first time users, you will be required to change your password. Enter and confirm your new password and select “change password”. You have successfully changed your password and will use this password at your next log in.

CHANGE PASSWORD

Use the form below to change your password.

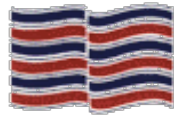
New passwords are required to be a minimum of 12 characters in length and contain at least one upper and lower case character and at least one special (non-alphanumeric) character..

Change Your Password

Password:

New Password:

Confirm New Password:



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To file a claim, select "File Claims".



CCSI

CONTRACT CLAIMS SERVICES, INC.

[[Log Out](#)]

- Home
- File Claims
- View Reports
- Forms
- My Profile
- Manage Users
- My Clients
- Contacts

Service Team



Vice President
 Renee Davis
[Email](#)
 800.743.2231 x2996



Asst. Manager
 Casey (Brands) Morgan
[Email](#)
 800.743.2231 x2997



Unit Clerk
 Lisa Sewell
[Email](#)
 800.743.2231 x3015



Executive Adjuster
 Ryan Martin
[Email](#)
 800.743.2231 x2976



Adjuster
 Marc Laufer
[Email](#)
 800.743.2231 x2983



Adjuster
 Amanda Shaw
[Email](#)
 800.743.2231 x2981



Adjuster
 Amber Mondello
[Email](#)
 800.743.2231 x2987



Army Central Insurance Fund

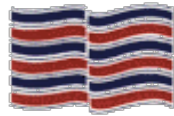
Welcome, Cameron McWaters!

Last Login: 9/13/2022 12:15:33 PM
Last Invalid Login: 9/10/2022 7:38:13 AM
Last Password Changed: 7/22/2022 11:27:13 AM
Password Expires In: 34 Days

Committed to Superior Service

CCSI is committed to exceeding the benchmarks and "best practices" established by our industry. We provide *superior service* in the following areas:

- Worldwide claims administration
- Medical cost control
- Legal services
- Staff longevity

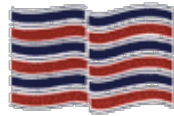


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You have now successfully logged into the application and have access to the LS-202 and LS-210. You will see the tabs in the upper left corner of your screen. Additionally you will notice there is an “EDIT” section and “AWAITING REVIEW” section. Once the information is completed on either the LS-202 or LS-210 and you select “save” the form will be saved in the “EDIT” window. Let’s get started with an LS-202 so you can see how this works. Select the LS-202 tab and click “new”. (You will notice when the tab is selected it is blue.)

The screenshot displays the application's navigation bar with the following tabs: Home, File Claims, View Reports, Change Password, Manage Users, My Service Team, and Contacts. Below this, there are two main tabs: LS202 (selected) and LS210. The LS202 tab contains a 'FROM:' section with 'New' and 'History' buttons, and a 'SELECTED:' section with 'Print', 'Review', and 'Delete' buttons. Below these are two data tables. The first table is titled 'EDIT' and has columns for 'Employee', 'Date of Inj', 'Date Last Edit', and 'Responsible'. The second table is titled 'AWAITING REVIEW' and has columns for 'Employee', 'Date of Inj', 'Date Submitted', and 'Submitted By'. Both tables show a single row of data with the number '1' at the bottom right of each table.



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To start an LS-202, you must first enter the SSN. (Format: 999999999) Once entered, click on the magnifying glass to the right. If the injured employee has any prior claims, certain fields will automatically display data. (DOB, phone number, address, etc....) Be sure to check the information to confirm it is accurate. If there are no prior or existing claims, proceed with completing the information by tabbing to each field and entering the information.

Home File Claims View Reports Change Password Manage Users My Service Team Contacts

LS202 LS210

LS-202
FIRST REPORT OF INJURY OR ILLNESS * Required Field for Submit

* Social Security No.

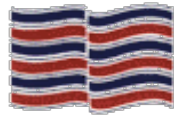
Searches the database for previous claim data.

OWCP No.

Date and Time of Accident
* Date : Time AM PM

Name of Injured/Deceased Employee
* Last Name * First Name MI Phone

Employee's Address
* Street
* City * State * Zip -



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Required fields will have a red asterisk. You will also see fields in orange, which represents a field that is auto filled and does not allow the user to change it. (Example: Injury is Reported Under the Following Act) Once you have entered the information, at the bottom you will see the option to "save" "submit" or "cancel". Let's discuss those in more detail.

Insurance Carrier		
CONTRACT CLAIMS SERVICES, INC		
Address		
P.O. BOX 541328		
City	State	Zip
DALLAS	TX	75354 - 1328
Employer		
US MARINE CORPS MCCS		
* Address		
* City	State	Zip
	---	-
Nature of Employer's Business		
Person Completing this Report	Official Title	Date of Report
CCS TESTER	TEST/TRAINING	08/16/2011
Rehired Annuitant	Retirement Participant	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
Special Comments to Supervisor or Adjuster		
<input checked="" type="checkbox"/> Auto Approve <input checked="" type="checkbox"/> Print Window		
Please review the information in the form for completeness and accuracy. You may select 'Save' to save the initial information and then retrieve it at a later time.		
Save Submit Cancel		



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Some fields require you to type the information, some require selecting “yes” or “no” and others have a drop down box. For the drop down box, click the arrow to the right to display the items from the drop down menu. By clicking the appropriate item the information will be entered for that field. Continue this process until the form is complete.

Service Team



Vice President
Renee Davis
[Email](#)
800.743.2231 x2996



Asst. Manager
Casey (Brands) Morgan
[Email](#)
800.743.2231 x2997



Unit Clerk
Lisa Sewell
[Email](#)
800.743.2231 x3015



Executive Adjuster
Ryan Martin
[Email](#)
800.743.2231 x2976



Adjuster
Marc Laufer
[Email](#)
800.743.2231 x2983

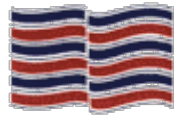


Adjuster
Amanda Shaw
[Email](#)
800.743.2231 x2981



Adjuster
Amber Mondello
[Email](#)
800.743.2231 x2987

Wages or Earnings (Include overtime, Allowances, etc.)	
Hourly \$	<input type="text"/>
Daily \$	<input type="text"/>
Weekly \$	<input type="text"/>
Yearly \$	<input type="text"/>
Exact Place where Accident Occured. This item should specify area if accident was in maritime employment and occured in area adjoining navigable waters.	
<input type="text"/>	
How was Knowledge of Accident or Occupational Illness gained?	
<input type="text"/>	
* Describe in full how the accident occurred	
<input type="text"/>	
Nature of Injury	
<ul style="list-style-type: none"> -- SELECT FROM LIST -- ABRASION AIDS/HIV RELATED PROBLEMS ALLERGIC REACTION AMPUTATION ANEURYSM ANGINA PECTORIS (HEART RELATE) ARTHRITIS ASBESTOSIS ASPHYXIATION ATTEMPTED SUICIDE BLACK LUNGS BURN - 1ST/2ND/3RD DEGREE BYSSINOSIS CANCER CARPAL TUNNEL SYNDROME CHEST PAINS CHIPPED TOOTH CHRONIC PAIN SYNDROME CONCUSSION CONJUNCTIVITIS CONTAGIOUS DISEASE CONTUSION/BRUISE CRUSHING CUMULATIVE INJURY CYST DEATH DEGENERATION DERMATITIS DISC HERNIATION 	



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You may opt to "save" a form if you are interrupted while entering the information, or if you have started the form, but need more information, prior to submitting. You will be asked if you want to save the form and finish later. By selecting yes, the form will save in the EDIT window. You must complete the "required" fields prior to saving. If these are not completed, a window will display requesting you complete the required fields and these fields will be displayed in yellow.

LS-202* Required Field for SubmitCancel

* Social Security No.

OWCP No.

Date and Time of Accident

* Date Time

: AM PM

Name of Injured/Deceased Employee

* Last Name * First Name

Employee's Address

* Street

* City * State * Zip

 -

Injury is Reported Under the Following Act

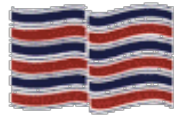
Longshore and Harbor Workers' Compensation Act

Message from webpage

There are minimal requirements to save the form:

- Last Name
- First Name
- Date of Injury

OK



Contract Claims Services Inc.

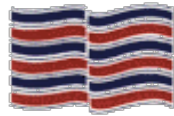
"Going the extra mile to meet the needs of our Clients"

By entering the required fields and selecting "save", you will now see the form in the Edit window. From the Edit window, you can "print" "review" or "delete" the form. To perform any of these tasks, you must first click on the form. You will notice when you place your cursor over the selected form, it will change to yellow, once selected it will change to orange. To print the form, select print. To delete the form, select delete. In most cases you will select "review" to complete the form.

The screenshot displays the web application interface for Contract Claims Services Inc. At the top left is the company logo. Below it is a navigation menu with the following items: Home, File Claims, View Reports, Change Password, Manage Users, My Service Team, and Contacts. The main content area shows two tabs: LS202 and LS210. Below the tabs is a control panel with 'FROM:' buttons for 'New' and 'History', and 'SELECTED:' buttons for 'Print', 'Review', and 'Delete'. The 'EDIT' section contains a table with the following data:

Employee	Date of Inj	Date Last Edit	Responsible
TEST , TEST	12/01/10	08/16/11 - 07:42 AM	CCS TESTER

Below the table is a footer with the number '1'. The 'AWAITING REVIEW' section is currently empty.



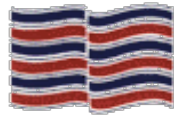
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By selecting review from the EDIT window, the form will be displayed. Complete the form to be processed by entering the additional information. Once the information is completed, prior to selecting submit be sure the "print window" box in the bottom right hand corner is checked. This will allow you to print the form prior to submitting.

Address		
P.O. BOX 541328		
City	State	Zip
DALLAS	TX	75354 - 1328
Employer		
US MARINE CORPS MCCS		
* Address		
123 MAIN STR		
* City	State	Zip
DALLAS	TX	75006 -
Nature of Employer's Business		
Person Completing this Report	Official Title	Date of Report
CCS TESTER	TEST/TRAINING	08/16/2011
Rehired Annuitant	Retirement Participant	
<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="radio"/> Yes <input checked="" type="radio"/> No	
Special Comments to Supervisor or Adjuster		
<input type="checkbox"/> Auto Approve <input checked="" type="checkbox"/> Print Window		
Please review the information in the form for completeness and accuracy. You may select 'Save' to save the initial information and then retrieve it at a later time.		
<input type="button" value="Save"/>	<input type="button" value="Submit"/>	<input type="button" value="Cancel"/>

Opens the print window upon submit.



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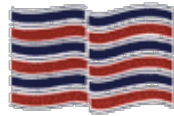
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When the print window is checked, a separate window will open displaying the form – this also gives you the opportunity to confirm the information is accurate.

https://www.ccsapps.com/members/dwc1_vs2005/Fo... Page Safety Tools

Please fill out the following form. You cannot save data typed into this form. Please print your completed form if you would like a copy for your records. Highlight Fields

Employer's First Report of Injury Or Occupational Illness		U.S. Department of Labor Employment Standards Administration Office of Worker's Compensation Programs		
JOB CLASS: REGULAR FULL TIME		HIRE DATE:	NAFI CODE: 30017 - BILLETING SAN DIEGO	OMB No. 1215-0031
1. OWCP No.	2. Carrier's No.	3. Date and Time of Accident Mo. Day Yr. Hour 12-01-2010 <input type="radio"/> AM <input type="radio"/> PM		
4. Name of Injured/Deceased Employee (Type or print – first, M.I., last) FIRST: TEST MI: T LAST: TEST TELEPHONE:		5. Employee's Address (No, street, city, state, Zip code) 123 MAIN STR DALLAS TX 75006		
6. Injury is Reported Under the Following Act (Mark One) A <input type="radio"/> Longshore and harbor Workers' Compensation Act B <input type="radio"/> Defense Base Act C <input checked="" type="radio"/> Nonappropriated Fund Instrumentalities Act D <input type="radio"/> Outer Continental Shelf Lands Act	7. Indicate Where Injury occurred (Longshore Act only)(Mark one) A <input type="radio"/> Aboard Vessel /Over Navigable Waters B <input type="radio"/> Pier/Wharf C <input type="radio"/> Dry Dock D <input type="radio"/> Marine Terminal E <input type="radio"/> Building Way F <input type="radio"/> Marine Railway G <input type="radio"/> Other Adjoining Area	8. Sex <input checked="" type="radio"/> M <input type="radio"/> F	9. Date of birth 12-01-1966	
		10. Social Security No. (Required by law) 999-99-9999		
14. Did Employee Stop Work Immediately? <input type="radio"/> Yes <input type="radio"/> No		15. Date and Hour Employee Returned to Work		12. Did Injury Cause Loss of Time Beyond Day or Shift of accident? <input type="radio"/> Yes <input type="radio"/> No
17. Did Injury/Death Occur on Employer's Premises? <input type="radio"/> Yes <input type="radio"/> No		18. Dept. in Which Employee Normally Works(ed) 85 - BILLETING (BOQ, BEQ, ETC.)		13. Date and Hour Employee First Lost Time Due to Injury Mo. Day Yr. Hour <input type="radio"/> AM <input type="radio"/> PM
20. Date and Hour Pay Stopped		21. Which Days Usually Worked Per Week? (Mark (X) day) S M T W T F S		19. Occupation Custodian/Janitor
				22. Date Employer or Employer First Know



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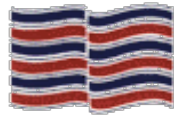
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Once a form is submitted to be processed, the user has the option to "print" "view" or "amend" the form. To amend the form select the form to be amended and click amend. The form will be displayed and is ready for you to enter the amendments. Once completed, select submit. Once submitted, the form will be displayed in the history window, awaiting processing by CCS.

The screenshot shows a web browser window with the following elements:

- Browser tabs: "CCS Portal" and "CCS Holdings, Inc."
- Header: "CCS HOLDINGS GROUP OF COMPANIES" logo and navigation links: "Home", "Administration", "Log Out".
- Content area: Two tabs labeled "LS202" and "LS210".
- Form area: A "SELECTED:" section with buttons for "Print", "View", and "Amend". A mouse cursor is hovering over the "Amend" button.
- Table: A "HISTORY" table with the following data:

Employee	Date of Inj	Approved	Processed	Claim Key
TOM , TOM	02/15/10	03/16/10 - 09:28 AM	Processing...	
- Footer: A search bar with "FIND:" label, a text input field, a dropdown menu set to "First Name", and "Search" and "Clear" buttons.



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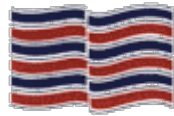
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Additional notes: You can only amend a form that has been processed and are only able to amend the latest version. An error message in the bottom right hand corner will be displayed in yellow letting you know the form "Must be Processed" or "Not most current".

The screenshot shows a web browser window with the address bar displaying "CCS Portal" and "CCS Holdings, Inc.". The page header includes the "CCS HOLDINGS GROUP OF COMPANIES" logo and a navigation menu with "Home", "Administration", and "Log Out". Below the menu, there are tabs for "LS202" and "LS210". The main content area features a "HISTORY" table with the following data:

Employee	Date of Inj	Approved	Processed	Claim Key
TOM , TOM	02/15/10	03/16/10 - 09:28 AM	Processing...	

At the bottom of the page, there is a search bar with a "FIND:" label, a text input field, a "First Name" dropdown menu, "Search" and "Clear" buttons, and a yellow button labeled "Must be Processed".



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To view the form in history, select "view". The form will be displayed, however you are only allow to view it. You cannot make any changes.

File Edit View Favorites Tools Help

CCS Portal CCS Holdings, Inc.

CCS HOLDINGS
GROUP OF COMPANIES

Home Administration Log Out

LS202 LS210

LS-202
FIRST REPORT OF INJURY OR ILLNESS [Back](#)

Social Security No.
123456789

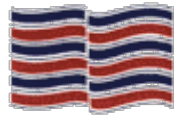
OWCP No.
[]

Date and Time of Accident
Date: 02/15/2010 Time: [] : [] AM PM

Name of Injured/Deceased Employee
Last Name: TOM First Name: TOM MI: [] Phone: []

Employee's Address
Street: 123 MAIN STREET
City: DALLAS State: TX Zip: 75006 - []

Injury is Reported Under the Following Act
 Longshore and Harbor Workers' Compensation Act
 Defense Base Act
 Nonappropriated Fund Injuries-Mentalities Act



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To print the form from the history window, select print. The form will be displayed in a separate window for you to print. You can also save the form, by selecting "file" "save as". This will open the form in a PDF for you to save.

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

REGULAR PART TIME HIRE DATE: NAFI CODE: 10016 - MCCS PARRIS ISLAND OMB No. 1215-0031

1. No. 2. Carrier's No. 3. Date and Time of Accident
Mo. Day Yr. Hour AM
 PM

4. Name of Injured/Deceased Employee (Type or print – first, M.I., last)
FIRST: TOM MI: LAST: TOM
TELEPHONE:

5. Employee's Address (No, street, city, state, Zip code)
123 MAIN STREET
DALLAS TX 75006

6. Injury is Reported Under the Following Act (Mark One)
 A Longshore and harbor Workers' Compensation Act
 B Defense Base Act
 C Nonappropriated Fund Instrumentalities Act
 D Outer Continental Shelf Lands Act

7. Indicate Where Injury occurred (Longshore Act only)(Mark one)
 A Aboard Vessel /Over Navigable Waters
 B Pier/Wharf
 C Dry Dock
 D Marine Terminal
 E Building Way
 F Marine Railway
 G Other Adjoining Area

8. Sex M F 9. Date of birth
12-15-1960

10. Social Security No. (Required by law)
123-45-6789

11. Did injury Cause Death?
 No Yes - if yes, skip to 16

12. Did Injury Cause Loss of Time Beyond Day or Shift of accident? Yes
 No

13. Date and Hour Employee First Lost Time Due to Injury Mo. Day Yr. Hour
 AM
 PM

14. Did Employee Stop Work Immediately? Yes
 No

15. Date and Hour Employee Returned to Work

16. Was Employee Doing Work When Injured/Killed? (If no, explain in Item 26) Yes
 No

17. Did Injury/Death Occur on Employer's Premises? Yes
 No

18. Dept. in Which Employee Normally Works(ed)
5 - E CLUB

19. Occupation
Buyer

20. Date and Hour Pay Stopped

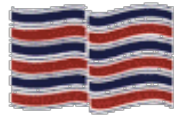
21. Which Days Usually Worked Per Week? (Mark (X) days) S M T W T F S

22. Date Employer or Foreman First Knew Of Accident. 03-01-2010

23. Wages or Earnings (Include

24. Exact Place where Accident Occurred (See Instructions)

25. How was Knowledge of Accident or



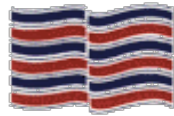
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Filing an LS-210 is similar to filing an LS-202. To complete an LS-210, select the LS-210 tab and new. You will be asked to enter the claim # or the First Name, Last Name and Date of Injury. Once entered, select start.

The screenshot shows a web browser window with the address bar displaying "CCS Portal" and "CCS Holdings, Inc.". The page header includes the CCS Holdings logo and a navigation menu with "Home", "Administration", and "Log Out". Below the menu are two tabs: "LS202" and "LS210". The "LS210" tab is active, and a form is displayed with the following fields:

- A "Back" button at the top right of the form area.
- A header: "PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE CLAIM:"
- A "Claim #" input field.
- An "OR" separator.
- Three input fields: "First Name", "Last Name", and "Date of Injury", with "AND" between "Last Name" and "Date of Injury".
- A "Start" button at the bottom right of the form area.



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The form will be displayed. The top portion is displayed orange indicating fields that cannot be changed. Scroll to box 7 and complete the information.

City: DALLAS State: TX Zip: 75354

7. Initial Period of Disability (Use Inclusive Dates for A and B)
A. From [] B. To [] C. Date Returned to Work: []

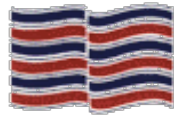
8. If this report covers a period of disability after the date shown in item 7C. State each subsequent period of disability. Use inclusive dates for A and B.
A. From [] B. To [] C. Date returned to work []
[] [] []
[] [] []
[] [] []

9. Did employee receive medical attention?
 Yes No
If Yes, give dates, names and addresses of doctors and hospitals providing. If No, explain.
[]

10. Was employee treated by his or her choice of physician?
 Yes No

11. Was form LS-1 given to employee when injury was reported to you?
 Yes No

12. Name of Employer (Firm Name)



Contract Claims Services Inc.

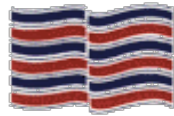
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Similar to the LS-202, you have the option to "save" "submit" or "cancel". These features work the same way as the LS-202. (Save for later, submit to be processed or cancel the form.) You can also view previously submitted LS-210s under history, where you can "print" "view" or "amend" similar to the LS-202.

The screenshot shows a web browser window with the following elements:

- Browser tabs: "CCS Portal" and "CCS Holdings, Inc."
- Header: "CCS HOLDINGS GROUP OF COMPANIES" logo and navigation menu with "Home", "Administration", and "Log Out".
- Form sections:
 - 9. Did employee receive medical attention?
 Yes No
If Yes, give dates, names and addresses of doctors and hospitals providing. If No, explain.
 - 10. Was employee treated by his or her choice of physician?
 Yes No
 - 11. Was form LS-1 given to employee when injury was reported to you?
 Yes No
 - 12. Name of Employer (Firm Name)
 - 13. Employer's Address

City: State: Zip:
 - Name of Person Signing: Title: Date of Report:
- Form controls: Auto Approve, Print Window
- Footer: "Please review the information in the form for completeness and accuracy. You may select 'Save' to save the initial information and then retrieve it at a later time." Buttons: Save, Submit, Cancel.



Contract Claims Services Inc.

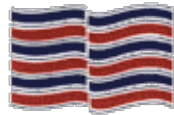
"Going the extra mile to meet the needs of our Clients"

If you are looking for a particular form you can search under "FIND" at the bottom of the history window. You can search by First Name, Last Name, Date of Injury or Amendments. Select the criteria and click "search". Only the forms meeting the criteria will be displayed. This feature can be used for both the LS-202 and the LS-210.

The screenshot shows a web browser window with the address bar displaying "CCS Portal" and "CCS Holdings, Inc.". The page header includes the CCS Holdings, Inc. logo and navigation links for "Home", "Administration", and "Log Out". Below the header, there are tabs for "LS202" and "LS210". The main content area displays a search history window with the following elements:

- A "Back" button on the left.
- A "SELECTED:" label followed by "Print", "View", and "Amend" buttons.
- A "HISTORY" section with a table containing one row of data.
- A "FIND:" search bar at the bottom with the text "TOM" entered, a dropdown menu set to "Last Name", a "Search" button, and a "Clear" button.

Employee	Date of Inj	Approved	Processed	Claim Key
TOM , TOM	02/15/10	03/16/10 - 09:28 AM	Processing...	



Contract Claims Services Inc.

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To log out of the application, select Log out. This will take you back to the Contract Claims Services, Inc. home page.

If you have any problems accessing or using the application, contact Lisa Sewell at 1-800-743-2231 ext. 3015 or email lisa.sewell@ccsholdings.com.



CCSI CONTRACT CLAIMS SERVICES, INC.

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Log On

Username:

Password:



[Forgot Your Password?](#)

Claims Operations

P.O. Box 541388
Dallas, TX 75354
800.743.2231 **Phone**
972.786.7349 **Fax**

Welcome

Welcome to the Contract Claims Services, Inc. website. Whether you are a current client or just browsing, we are glad you stopped by. If you are a current client, please sign in and take advantage of the many services available to you.

CCSI is a privately held, employee-owned company located in Dallas, TX. We are the leading third party administrator (TPA) for federal workers' compensation in

News & Updates

- DOL posts 2013 OWCP medical fee schedule. There are significant changes in fee schedule reimbursement for some services such as an MRI of the knee. The reimbursement for an MRI of the knee was reduced over 35% in the 2013 fee schedule. Anyone managing longshore claims or with longshore claims exposure should confirm their bill auditor is now using the updated fee schedule.

Client Portal Contact List

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