Print Reset

DEEOIC Durable Medical Equipment Authorization Request

(Fax # 1-800-882-6147)

Please read the instructions carefully before completing authorization request. Complete all applicable fields. All Prior Authorization requests with supporting documentation must either be faxed with this template or its equivalent or be submitted through the Web Bill Processing Portal (https://owcpmed.dol.gov). Please include the DEEOIC Claimant Case ID on all pages. Incomplete requests cannot be processed and will be returned.

PART A: Requestor Information

A1. Date Requested:

A2. Requested By:

A3. Phone Number:

PART B: Claimant Information

B1. Claimant's Case ID:

B2. Date of Birth:

B3. First Name:

B4. Last Name:

PART C: Provider Information

C1. OWCP Provider ID:

C2. Tax ID (SSN/FEIN):

C3. Name:

C4. Fax Number:

C5. Providing care for a family member?:

C6. If Yes, please provide relationship to the claimant:

PART D: Service Line Information

D1. Diagnosis Codes: A. B. C. D.

D2.

From Date	To Date	Diagnosis Pointer A	B	C	D	Code Type	Procedure Code	Units	Rental or Purchase Modifier	Cost	Duration

D3. Remarks:

PART E: Supporting Documents

All supporting documents must be attached to the request. Failure to include supporting documentation may result in a delay in processing or denial. See instructions for required documents. Please ensure to include claimant's case ID on each page.

Instructions

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Part A: Requestor Information		
A1.	Type or print date on which this template is being completed.	Required
A2.	Type or print name of the person requesting an authorization.	Required
A3.	Type or print phone number of the person requesting an authorization.	

Part B: Claimant Information		
B1.	Type or print claimant's case ID.	Required
B2.	Type or print claimant's date of birth (mm/dd/yyyy).	Required
B3.	Type or print claimant's first name.	Required
B4.	Type or print claimant's last name.	Required

Part C: Provider Information		
C1.	Type or print service rendering provider's OWCP ID.	Required
C2.	Type or print provider's Tax ID (SSN or FEIN).	Required
C3.	Type or print provider's name.	Required
C4.	Type or print fax number. If entered, this fax number will be used for communication related to this authorization request. Leave it blank if fax number was provided during provider enrollment.	
C5.	Select an option if providing care for a family member • Yes • No	Required
C6.	Type or print relationship to the claimant.	Required if "Yes" is selected in field C5

Part D: Service Line Information		
D1.	Type or print ICD-09 or ICD-10 diagnosis codes for which services are being rendered, up to 4 codes are allowed. ICD-9 code is applicable if date of service is prior to 09/30/2015. Use ICD-10 code if date of service is after 10/01/2015.	Required
D2.	Service lines.	
	Type or print beginning date of the service.	Required
	Type or print end date of the service.	Required
	Select diagnosis code pointer from the diagnosis codes listed in Part D: A, B, C, D Select all applicable options.	Required
	Select code type from following options: • CPT Procedure Code • HCPCS Procedure Code	Required
	Type or print applicable procedure code.	Required
	Type or print number of units requested.	Required
	Select rental or purchase modifier from following options: • RR - Rental • NU – Purchased New • UE – Purchased Used	Required
	Type or print total cost.	Required
	Type or print duration for Rental. e.g., 2 months	Required for RR modifier
D3.	Type or print additional notes or remarks, if any.	

Part E: Supporting Documentation		
	Letter of medical necessity, prescription and information regarding the requested equipment and how it meets the physician's prescription.	