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**PART E: Service Line Information**

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E1. Specific Body Part to be treated:

E2. Diagnosis Codes:           A.                           B.                           C.                           D.

E3. Has this surgery been performed previously on the same anatomical site?:

E4. Will this claimant require Home Health Services after surgery?:

E5. Will this claimant require Physical/Occupational Therapy Services after surgery?:

E6.

From Date	To Date	Diagnosis Pointer				Code Type	Procedure Code	Modifier	Body Part Modifier	Units/Days Requested
		A	B	C	D					

E7. Remarks:

Note: To request Prior Authorization for Home Health Services or Physical Therapy Services after Surgery, these professionals must use the **Home Health Services or Physical Therapy/Occupational Therapy Authorization Request Form.**

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**PART F: Supporting Documents**

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All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

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## Instructions

Please read the instructions carefully before completing authorization request. Complete all applicable fields. All Prior Authorization requests must either be faxed on this template or be submitted through the Web Bill Processing Portal (<https://owcpmed.dol.gov>). Fax with supporting medical documentation, including the case file number on all pages. Incomplete requests cannot be processed and will be returned.

<b>Part A: Requestor Information</b>		
A1.	Select an appropriate option for initial or correction request  Initial Request – New or first-time request Correction – To update or correct erroneous data elements	Required
A2.	Type or print an original authorization number if correction request is being submitted. If you don't have authorization number, provide details about the original authorization, such as claimant's case ID, procedure code, date of service, requested units etc. if they are being changed in Remarks field	
A3.	Type or print date on which this template is being completed	Required
A4.	Type or print name of the person requesting an authorization	Required
A5.	Type or print phone number of the person requesting an authorization	

<b>Part B: Claimant Information</b>		
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
B5.	Type or print claimant's date of injury (mm/dd/yyyy)	Required

<b>Part C: Provider Information</b>		
C1.	Select an appropriate option if primary surgeon is completing this form	Required
C2.	Type or print service rendering provider's OWCP ID	Required
C3.	Type or print provider's Tax ID (SSN or FEIN)	Required
C4.	Type or print provider's name	Required
C5.	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.	

<b>Part D: Surgery Information</b>		
D1.	Type or print date of the surgery	Required
D2.	Select an appropriate surgery site option from the following options: <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> <li>• ASC</li> <li>• Office</li> </ul>	Required
D3.	Select all applicable professionals performing surgery	Required

<b>Part E: Service Line Information</b>		
E1.	Type or print a specific body part that requires treatment,	Required
E2.	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 on/prior to 09/30/2015. Use ICD-10 code if date of service is on/after 10/01/2015.	Required
E3.	Select an appropriate option if similar surgery was performed at the same site <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>	Required

E4.	Select an appropriate option if claimant requires post-surgery home health services <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>	Required
E5.	Select an appropriate option if claimant requires post-surgery PT/OT services <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>	Required
E6.	Service lines (Please enter each procedure code on a separate line.)	
	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: <ul style="list-style-type: none"> <li>• CPT Procedure Code</li> <li>• HCPCS Procedure Code</li> </ul>	Required
	Type or print applicable procedure code/ revenue code Refer to below link for the list of procedure codes that can be performed at ASC. Navigate to the year based on the date of service to view or download the list <a href="https://www.dol.gov/owcp/regs/feeschedule/accept.htm">https://www.dol.gov/owcp/regs/feeschedule/accept.htm</a>	Required
	Type or print procedure code modifier	
	Select body part modifier from following options: <ul style="list-style-type: none"> <li>• RT – Right Side</li> <li>• LT – Left Side</li> <li>• 50 – Bilateral</li> </ul>	
	Type or print units or days requested	Required
E7.	Type or print additional notes or remarks, if any	

<b>Part F: Supporting Documentation</b>		
	Supporting medical documentation, if applicable	