Print Reset

DFEC Surgical Package Authorization Request

(Fax # 1-800-215-4901)

All Prior Authorization requests must be faxed on this template or submitted via the CBP Bill Processing Portal. Fax with supporting documentation, including the Claimant ID on all pages. All fields marked as required must be completed/checked. If the surgery will be rendered at an Inpatient (more than 24 hours) or Outpatient/ Ambulatory Surgery Center (ASC) facility (less than 24 hours), all fields of Professionals at Surgery must be checked. If the surgery will be rendered in an Office (less than 8 hours), check only the Physician/Surgeon, Physician's Assistant, and/or CRNA. (Note: All parties must already be enrolled in the DFEC Program). Refer to this link for the list of procedure codes that can be performed at an ASC; Navigate to the year based on the date of service to view or download the list, https://www.dol.gov/agencies/owcp/regs/feeschedule/accept. NOTE: Non-Surgical procedure codes cannot be submitted on this template. Please refer to the other authorization request templates for non-surgical codes.

PART A: Requestor Information

A1. ☐ Initial Request ☐ Correction

A2. Original Authorization Number (For Correction):

A3. Date Requested:

A4. Requested By:

A5. Phone Number:

PART B: Claimant Information

B1. Claimant's Case ID:

B2. Date of Birth:

B3. First Name:

B4. Last Name:

B5. Date of Injury:

PART C: Provider Information

C1. Are you the Primary Surgeon?:

C2. OWCP Provider ID:

C3. Tax ID (SSN/FEIN):

C4. Name:

C5. Fax Number:

PART D: Surgery Information

D1. Date of Surgery:

D2. ☐ INPATIENT SURGERY (More than 24 hours) – Include all Proposed Professionals in the Operating Room.

☐ OUTPATIENT (Less than 24 hours) – Include all Proposed Professionals in the Operating Room.

☐ ASC SURGERY – Include all Proposed Professionals in the Operating Room.

☐ OFFICE SURGERY (Less than 8 hours) – Include all Proposed Professional present during surgical procedure.

D3. Check the location/professional requiring authorization for this surgery, to include the Surgeon submitting this form.

SELECT PROFESSIONAL	PROFESSIONAL AT SURGERY
	Facility
	Surgeon
	Co-Surgeon
	Asst Surgeon
	CRNA
	Anesthesiologist
	Physician Asst

PART E: Service Line Information

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 A B C D	Code Type	Procedure Code	Modifier	Body Part Modifier	Units/Days Requested

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 Template.**

PART F: Supporting Documents

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.

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.

Part A: Requestor Information		
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	

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
B5.	Type or print claimant's date of injury (mm/dd/yyyy)	Required

Part C: Provider Information		
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.	

Part D: Surgery Information		
D1.	Type or print date of the surgery	Required
D2.	Select an appropriate surgery site option from the following options: • Inpatient • Outpatient • ASC • Office	Required
D3.	Select all applicable professionals performing surgery	Required

Part E: Service Line Information		
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 • Yes • No	Required

E4.	Select an appropriate option if claimant requires post-surgery home health services • Yes • No	Required
E5.	Select an appropriate option if claimant requires post-surgery PT/OT services • Yes • No	Required
E6.	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 NOTE: NON-Surgical Procedure Codes cannot be submitted on surgical package authorization Valid code range 10021 – 69990 and 0275T	Required
	Type or print procedure code modifier	
	Select body part modifier from following options: • RT – Right Side • LT – Left Side • 50 – Bilateral	
	Type or print units or days requested	Required
E7.	Type or print additional notes or remarks, if any	

Part F: Supporting Documentation		
	Supporting medical documentation, if applicable	