Print Reset

DFEC Travel Authorization Request

(Fax # 1-800-215-4901)

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 Claimant ID on all pages. Incomplete requests cannot be processed and will be returned.

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. 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: Travel Information

D1. Travel From:

D2. Travel To:

D3.

From Date	To Date	Travel Code	Estimated Total Charge	Estimated Miles

D4. Remarks:

PART E: 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		Required, if completed by provider. Leave this section blank, if completed by claimant.
C1.	Type or print service rendering provider's OWCP ID	
C2.	Type or print provider's Tax ID (SSN or FEIN)	
C3.	Type or print provider's name	
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	
C6.	Type or print relationship to the claimant	Required if "Yes" is selected in field C5

Part D: Travel Information		
D1.	Select origin of travel from following options: • Home • Hospital • Lab • Office/Clinic • Pharmacy • Work	Required
D2.	Select destination of travel from following options: • Home • Hospital	Required

	• Lab • Office/Clinic • Pharmacy • Work	
D3.	Service lines	
	Type or print beginning date of the service	Required
	Type or print end date of the service	Required
	Select travel code from following options: • A0100 - Taxi • A0110 - Bus, intra- or interstate carrier • A0120 - Mini-Bus, mountain area transports, and other transports • A0130 - Wheelchair Van • A0140 – Air Travel • A0170 - Transport Parking Fees/Tolls • A0180 – Lodging (applicable only for claimant) • A0190 – Meals (applicable only for claimant) • A0080 – Total Trip Miles (with no vested interest) A0090 – Total Trip Miles (with vested interest)	Required
	Type or print total estimated charges for codes A0100 to A0190 if dollar amount is greater than $75.00. They are authorized based on private transportation total charges	
	Type or print estimated miles for code A0080 and A0090 if greater than 100 miles. Travel service is authorized based on total round trip miles	
D4.	Type or print additional notes or remarks, if any	

Part E: Supporting Documentation		
	Supporting medical documentation, if applicable	