DEEOIC Authorization Templates

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Overview

When claimants are treated for their work-related injuries and/or occupational diseases, certain services require an authorization. Providers must submit the appropriate authorization template. Authorizations must be approved for such services rendered before any payments can be reimbursed.

Services that require authorization are categorized by levels. Level 3 services will require completion of an authorization template. To determine if a service requires an authorization, visit the Office of Workers' Compensation Programs, Medical Bill Processing Portal at https://owcpmed.dol.gov or you can speak with a customer service representative at 844-493-1966 beginning April 27, 2020.

The new authorization templates have been changed and will be available **view only** beginning April 13, 2020, on the pre-go-live Portal at https://prod.wcmbp.com/outreach/.

Note: The authorization templates will not be available for submission until April 27, 2020.

Durable Medical Equipment Template

Durable Medical Equipment Template

Durable Medical Equipment that are level's 2 or 3, will require the completion of a DME Authorization Template.

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.

Completing the Durable Medical Equipment Template

PART A: Requestor Information

A1. Date Requested:	
A2. Requested By:	A3. Phone Number:

A1. Enter the date the authorization is being completed.

A2. Enter the name of the person requesting the authorization.

A3. Enter the phone number of the person requesting the authorization. **(Not Required)**

Completing the Durable Medical Equipment Template

B1. Enter the Claimant's 9 digit Case ID.

B2. Enter the Date of Birth (mm/dd/yyyy).

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

Note: All fields in Part B are required.

PART B: Claimant Information

B1. Claimant's Case ID:	B2. Date of Birth:
B3. First Name:	B4. Last Name:

Completing the Durable Medical Equipment Template

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:

C1. Enter the provider's 9-digit OWCP Provider Identification Number (PIN).

C2. Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.

C3. Enter the Provider's Name.

C4. Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the providers profile, it can be left blank. **(Not Required)**

C5. Confirm if you are providing care for a family member or not.

C6. If you are providing care, state your relationship to the claimant. **(Only required if Yes was selected in C5)**

Completing the Durable Medical Equipment Template

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:

D1. Up to four ICD-9 or ICD-10 codes can be entered.

- ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

D2.

- Enter the DOS range.
- Enter the Diagnosis you want to point to from D1, multiple pointers can be selected.
- Select the Code Type (HCPCS).
- Enter the Procedure Code (HCPCS).
- Enter the Units requested.
- Select RR (for Rental), NU (for Purchased New) or EU (for Purchased Used).
- Enter the total Cost for the full DOS range.
- Enter duration **(Required For Rentals Only).**

D3. Enter any additional notes you may have **(Not Required).**

Completing the Durable Medical Equipment Template

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.

Letter of medical necessity, prescription and information regarding the requested equipment along with how it meets the physician's prescription.

* Write the Claimant's Case ID on all additional pages submitted with the template.

CNSI

General Medical Template

General Medical Template

General Medical Services that are level 2 or 3, will require the completion of a General Medical Authorization Template.

DEEOIC General Medical 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. Is this an implant?: D3. Cost of implant:

D4. Place of Service (Select one)
- Ambulatory Surgery Center (ASC)
- Home
- Office
- Outpatient

D5.

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

D6. 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.

CNSI

Completing the General Medical Template

PART A: Requestor Information	
A1. Date Requested:	
A2. Requested By:	A3. Phone Number:

A1. Enter the date the authorization is being completed.

A2. Enter the name of the person requesting the authorization.

A3. Enter the phone number of the person requesting the authorization. **(Not Required)**

CNSI

Completing the General Medical Template

B1. Enter the Claimant's 9 digit Case ID.

B2. Enter the Date of Birth (mm/dd/yyyy).

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

Note: All fields in Part B are required.

PART B: Claimant Information

B1. Claimant's Case ID:	B2. Date of Birth:
B3. First Name:	B4. Last Name:

CNSI

Completing the General Medical Template

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:

C1. Enter the provider's 9-digit OWCP Provider Identification Number (PIN).

C2. Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.

C3. Enter the Provider's Name.

C4. Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the providers profile, it can be left blank. **(Not Required)**

C5. Confirm if you are providing care for a family member or not.

C6. If you are providing care, state your relationship to the claimant. **(Only required if Yes was selected in C5)**

Completing the General Medical Template

PART D: Service Line Information

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

D2. Is this an implant?: D3. Cost of implant:

D4. Place of Service (Select one)
- Ambulatory Surgery Center (ASC)
- Home
- Office
- Outpatient

D5.

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

D6. Remarks:

D1. Up to four ICD-9 or ICD-10 codes can be entered.
- ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

D2. State if this is an implant?

D3. If this is for an implant, how much does it cost?

D4. Select the place were service was rendered.

D5.
- Enter the DOS range.
- Enter the Diagnosis you want to point to from D1, multiple pointers can be selected.
- Select the code type (CPT/HCPCS/RCC/NDC) **Note:** Select Revenue Code type for Outpatient Facility services as per instructions.
- Enter Revenue Code if applicable.
- Enter Procedure Code (CPT, HCPCS or NDC).
- Enter the code Modifier (if applicable).
- Enter Units Requested.

D6. Enter any additional remarks.

Completing the General Medical Template

Attach any supporting documentation that may help. (**Not required**)

* Write the Claimant's Case ID on all additional pages submitted with the template.

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.

CNSI

Home Health Template

Home Health Template

Home Health Services that are level 3, will require the completion of the Home Health Template.

DEEOIC Home Health 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. ☐ Initial Request ☐ Re-Authorization ☐ Amendment ☐ 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:

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 Plan Information

D1. Service Type:

D2. Diagnosis Codes: A. B. C. D.

D3.

From Date	To Date	Diagnosis Pointer A	B	C	D	Procedure Code	Frequency	Duration	Total Units Request

D4. 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.

CNSI

Completing the Home Health Template

PART A: Requestor Information

A1. ☐ Initial Request ☐ Re-Authorization ☐ Amendment ☐ Correction

A2. Original Authorization Number (For Correction):

A3. Date Requested:

A4. Requested By:

A5. Phone Number:

A1. Select an option:

- Initial Request (new or first time requesting an authorization).
- Re-Authorization (to request the same level of care as the previous request).
- Amendment (to request a different level of care).
- Correction (to update or correct an authorization that is currently on file).

A2. If making a correction to an authorization that is on file, list the authorization number that is on file.

A3. Enter the date the authorization is being completed.

A4. Enter the name of the person requesting the authorization.

A5. Enter the phone number of the person requesting the authorization. **(Not Required)**

CNSI

Completing the Home Health Template

B1. Enter the Claimant's 9 digit Case ID (listed on the front of the new MBIC).

B2. Enter the Date of Birth (mm/dd/yyyy).

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

Note: All fields in Part B are required.

PART B: Claimant Information

B1. Claimant's Case ID:	B2. Date of Birth:
B3. First Name:	B4. Last Name:

CNSI

Completing the Home Health Template

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:	

C1. Enter the provider's 9-digit OWCP Provider Identification Number (PIN).

C2. Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.

C3. Enter the Provider's Name.

C4. Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider's profile, it can be left blank. **(Not Required)**

C5. Confirm if you are providing care for a family member or not.

C6. If you are providing care, state your relationship to the claimant. **(Only required if Yes was selected in C5.)**

CNSI

Completing the Home Health Template

PART D: Service Plan Information

D1. Service Type:

D2. Diagnosis Codes: A. B. C. D.

D3.

From Date	To Date	Diagnosis Pointer				Procedure Code	Frequency	Duration	Total Units Request
		A	B	C	D				

D4. Remarks:

D1. Select the Service Type (Assisted Living, HHC, Hospice or Nursing Home).

D2. Up to four ICD-9 or ICD-10 codes can be entered.

- ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

D3.

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Select the applicable HH code from the available options.
- Enter the Frequency (How many times a week will the claimant be seen?)
- Enter the Duration (How many total weeks will the claimant be seen?)
- Enter the Total Units Requested (Frequency x Duration = Total Units Requested)

D4. Enter any additional remarks

Completing the Home Health Template

Letter of medical necessity, evidence of face to face exam, plan of care, and any other medical documentation supporting the need for care as it relates to the accepted condition(s).

* Write the Claimant's Case ID on all additional pages submitted with the template.

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.

CNSI

Rehabilitative Therapies Template

Rehabilitative Therapies Template

Providers that are rendering Physical Therapy, Occupational Therapy, Speech Therapy, Massage Therapy or other Rehabilitative Therapies will require the completion of a Rehabilitative Therapies Authorization Template.

DEEOIC Rehabilitative Therapies Authorization Request

(Physical Therapy, Occupational Therapy, Speech Therapy, Massage Therapy or Other Rehabilitative Therapies)

(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. ☐ Initial Request ☐ Re-Authorization ☐ Amendment ☐ 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:

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: Therapy Plan Information

D1. Place of Service (Select one)

☐ Home ☐ Facility ☐ Office ☐ Outpatient

D2. Diagnosis Codes: A. B. C. D.

D3.

From Date	To Date	Diagnosis Pointer				Code Type	Procedure Code	# of units per procedure/visit	Frequency	Duration	Total units requested
		A	B	C	D						

D4. 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.

Completing the Rehabilitative Therapies Template

PART A: Requestor Information

A1. ☐ Initial Request ☐ Correction

A2. Original Authorization Number (For Correction):

A3. Date Requested:

A4. Requested By: A5. Phone Number:

A1. Select an option:

- Initial Request (new or first time requesting an authorization).
- Correction (to update or correct an authorization that is currently on file).

A2. If making a correction to an authorization that is on file, list the authorization number that is on file.

A3. Type the date the authorization is being completed.

A4. Enter the name of the person requesting the authorization.

A5. Enter the phone number of the person requesting the authorization. **(Not Required)**

Completing the Rehabilitative Therapies Template

B1. Enter the Claimant's 9 digit Case ID.

B2. Enter the Date of Birth (mm/dd/yyyy).

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

Note: All fields in Part B are required.

PART B: Claimant Information

B1. Claimant's Case ID:	B2. Date of Birth:
B3. First Name:	B4. Last Name:

CNSI

Completing the Rehabilitative Therapies Template

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:	

C1. Enter the provider's 9-digit OWCP Provider Identification Number (PIN).

C2. Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.

C3. Enter the Provider's Name.

C4. Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the providers profile, it can be left blank. **(Not Required)**

C5. Confirm if you are providing care for a family member or not.

C6. If you are providing care, state your relationship to the claimant. **(Only required if Yes was selected in C5)**

Completing the Rehabilitative Therapies Template

D1. Select a Place of Service (Home, Facility, Office or Outpatient).

D2. Up to four ICD-9 or ICD-10 codes can be entered.

- ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

D3.

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Select code type (CPT/HCPCS/Revenue Code/NDC Code).
- Enter the Procedure Code.
- Enter the # of Units Per Procedure/Visit (1 unit = 15 mins).
- Enter the frequency (How many times a week will the claimant be seen?)
- Enter the duration (How many total weeks will the claimant be seen?)
- Enter the total units requested (# of Units Per Procedure x Frequency x Duration = Total Units Requested).

D4. Enter any additional remarks.

PART D: Therapy Plan Information

D1. Place of Service (Select one)

☐ Home ☐ Facility ☐ Office ☐ Outpatient

D2. Diagnosis Codes: A. B. C. D.

D3.

From Date	To Date	Diagnosis Pointer				Code Type	Procedure Code	# of units per procedure/visit	Frequency	Duration	Total units requested
		A	B	C	D						

D4. Remarks:

Transplant Template

Transplant Template

Transplants will require the completion of a DEEOIC Transplant Authorization Template.

DEEOIC Transplant 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:
B5. Authorized Representative: B6. Phone Number:

PART C: Provider Information

C1. OWCP Provider ID: C2. Tax ID (SSN/FEIN):
C3. Name: C4. Fax Number:

PART D: Treating Physician Information

D1. Treating Physician:
D2. Treating Physician Address:

PART E: Service Line Information

E1. Diagnosis Codes: A. B. C. D.
E2.

From Date	To Date	Diagnosis Pointer				Code Type	Procedure Code
		A	B	C	D		

E3. Remarks:

PART F: Transplant Information

F1. Transplant Facility: F2. Transplant Type:
F3. Transplant Facility Address:
F4: Transplant Facility Phone:
F5. Organ Transplant Coordinator Name: F6. Phone Number:

PART G: 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.

Required documentation:

- Letter of medical necessity from the treating physician describing the need for the transplant being requested.
- Initial and recent clinical evaluation (i.e., diagnostic studies and laboratory tests)
- A copy of the treatment protocol

CNSI

Completing the Transplant Template

PART A: Requestor Information

A1. Date Requested:	
A2. Requested By:	A3. Phone Number:

A1. Enter the date the authorization is being completed.

A2. Enter the name of the person requesting the authorization.

A3. Enter the phone number of the person requesting the authorization. **(Not Required)**

CNSI

Completing the Transplant Template

B1. Enter the Claimant's 9 digit Case ID (listed on the front of the new MBIC).

B2. Enter the Date of Birth (mm/dd/yyyy).

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

Note: All fields in Part B are required.

PART B: Claimant Information	
B1. Claimant's Case ID:	B2. Date of Birth:
B3. First Name:	B4. Last Name:
B5. Authorized Representative:	B6. Phone Number:

CNSI

Completing the Transplant Template

PART C: Provider Information	
C1. OWCP Provider ID:	C2. Tax ID (SSN/FEIN):
C3. Name:	C4. Fax Number:

C1. Enter the provider's 9-digit OWCP Provider Identification Number (PIN).

C2. Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.

C3. Enter the Provider's Name.

C4. Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider's profile, it can be left blank. **(Not Required)**

Completing the Transplant Template

D1. Enter the Treating Physician's name.

D2. Enter the Treating Physician's Address.

PART D: Treating Physician Information	
D1. Treating Physician:	
D2. Treating Physician Address:	

CNSI

Completing the Transplant Template

PART E: Service Line Information

E1. Diagnosis Codes: A. B. C. D.

E2.

From Date	To Date	Diagnosis Pointer				Code Type	Procedure Code
		A	B	C	D		

E3. Remarks:

E1. Up to four ICD-9 or ICD-10 codes can be entered.

- ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.

E2.

- Enter the DOS range.
- Select the Diagnosis you want to point to from E2, multiple pointers can be selected.
- Select if the code is a HCPCS or CPT code.
- Enter the Procedure Code.

E3. Enter any additional remarks.

Completing the Transplant Template

PART F: Transplant Information

F1. Transplant Facility:	F2. Transplant Type:
F3. Transplant Facility Address:	
F4: Transplant Facility Phone:	
F5. Organ Transplant Coordinator Name:	F6. Phone Number:

F1. Enter the name of the Transplant Facility.

F2. Enter the type of Transplant being done.

F3. Enter the Transplant Facility Address.

F4. Enter the Transplant Facility Phone number.

F5. Enter the name of the person coordinating the organ transplant.

F6. Enter the coordinator's Phone Number.

CNSI

Completing the Transplant Template

PART G: 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.

Required documentation:

- ☐ Letter of medical necessity from the treating physician describing the need for the transplant being requested.
- ☐ Initial and recent clinical evaluation (i.e., diagnostic studies and laboratory tests)
- ☐ A copy of the treatment protocol

All supporting documentation is required.

* Write the Claimant's Case ID on all additional pages submitted with the template.

CNSI

Medical Transportation Template

Medical Transportation Template

Providers rendering the below travel services will require the completion of a Travel Template:

- **A0100** - Taxi
- **A0110** - Bus, intra- or interstate carrier
- **A0120** - Mini-Bus, mountain area transports, and other transports
- **A0130** - Wheelchair Van

DEEOIC Medical Transportation Authorization Request
(Fax # 1-800-882-6147)

Please read the instructions carefully before completing authorization request. Complete all applicable fields. All Prio Authorization requests with supporting documentation must either be faxed with this template or its equivalent or b submitted through the Web Bill Processing Portal (https://owcpmed.dol.gov). Please include the DEEOIC Claimant Case I 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: Transportation Information

D1. Transportation From:

D2. Transportation To:

D3.

From Date	To Date	Transportation Code	Estimated Total Charge

D4. 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.

Completing the Travel Template

PART A: Requestor Information

A1. Date Requested:	
A2. Requested By:	A3. Phone Number:

A1. Enter the date the authorization is being completed.

A2. Enter the name of the person requesting the authorization.

A3. Enter the phone number of the person requesting the authorization. **(Not Required)**

Completing the Travel Template

B1. Enter the Claimant's 9 digit Case ID (listed on the front of the new MBIC).

B2. Enter the Date of Birth (mm/dd/yyyy).

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

Note: All fields in Part B are required.

PART B: Claimant Information

B1. Claimant's Case ID:		B2. Date of Birth:	
B3. First Name:		B4. Last Name:	

Completing the Travel Template

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:

C1. Enter the provider's 9-digit OWCP Provider Identification Number (PIN).

C2. Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.

C3. Enter the Provider's Name.

C4. Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the providers profile, it can be left blank. **(Not Required)**

C5. Confirm if you are providing care for a family member or not.

C6. If you are providing care, state your relationship to the claimant. **(Only required if Yes was selected in C5)**

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D1. Select the location where your travel started from.

D2. Select the location where your travel ended.

D3.
- Enter the travel From and To date.
- Select the Transportation Code (A0100/A0110/A0120/A0130).
- Enter the Estimated Total Charge amount.

D4. Enter any additional remarks.

PART D: Transportation Information

D1. Transportation From:

D2. Transportation To:

D3.

From Date	To Date	Transportation Code	Estimated Total Charge

D4. Remarks:

Completing the Travel Template

Attach receipts or invoices to confirm the estimated total charge.

* Write the Claimant's Case ID on all additional pages submitted with the template.

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.

CNSI

Authorization Submission Methods

Authorization Templates can be submitted via:

- **Direct Data Entry (DDE)** in the Workers' Compensation Medical Bill Processing (WCMBP) System.
- **Fax** at 800.882.6147.
- **Mail** to PO Box 8304 London, KY 40742-8304.

Authorizations are available for status within 1 business days of receipt. To check on your Authorization status, visit the Office of Workers' Compensation Programs, Medical Bill Processing Portal at https://owcpmed.dol.gov or you can speak with a customer service representative at 844-493-1966 beginning April 27, 2020.

THANK YOU!