DEEOIC Authorization Templates
Introduction

- Overview
- How to Complete the DEEOIC Authorization Templates:
  - Durable Medical Equipment (DME)
  - General Medical
  - Home Health
  - Rehab
  - Transplant
  - Medical Transportation
- Authorization Submission Methods
When claimants are treated for their work-related injuries 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 require completion of an authorization template. To determine if a service requires an authorization, refer to the Office of Workers' Compensation Programs, Medical Bill Processing Portal (https://owcpmed.dol.gov) or contact a customer service representative at 844-493-1966.
Durable Medical Equipment Template
Durable Medical Equipment that are levels 2 or 3 require the completion of a DME Authorization Template.

**Note:**

Effective 06/24/2023, a separate DEEOIC DME supplies and accessories authorization is not required if:

- a rental authorization is approved for the related DME and service dates are within the rental period.
- a purchase authorization is approved for the related DME and service dates are within three (3) years of the purchase period.
Completing the Durable Medical Equipment Template
Continued (1 of 5)

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)

<table>
<thead>
<tr>
<th>PART A: Requestor Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1. Date Requested:</td>
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<tr>
<td>A2. Requested By:</td>
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<tr>
<td>A3. Phone Number:</td>
</tr>
</tbody>
</table>
B1. Enter the Claimant’s nine (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.
C1. Enter the Provider’s nine (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 Provider’s profile, it can be left blank. (Not Required)

C5. Confirm whether you are providing care for a family member.

C6. If the answer to C5 is Yes, enter your relationship to the claimant. (Only required if Yes is selected in C5)
Completing the Durable Medical Equipment Template
Continued (4 of 5)

D1. Enter up to four (4) ICD-9 or ICD-10 codes.

Note: ICD-9 code is applicable if date of service is on or prior to September 30, 2015. Use ICD-10 code if date of service is on or 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 the Duration (Only Required for Rentals)

D3. Enter any additional notes you may have (Not Required).
Include a letter of medical necessity, prescription, and information regarding the requested equipment along with how it meets the physician’s prescription.

**Important!** Be sure to include the Claimant’s Case ID on all additional pages submitted with the template.
General Medical Template
General Medical Services that are level 2 or 3 require the completion of a General Medical Authorization Template.
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 General Medical Template
Continued (2 of 5)

**B1.** Enter the Claimant’s nine (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.

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**PART B: Claimant Information**

<table>
<thead>
<tr>
<th>B1. Claimant’s Case ID:</th>
<th>B2. Date of Birth:</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>B3. First Name:</th>
<th>B4. Last Name:</th>
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<tbody>
<tr>
<td></td>
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</table>

**Note:** All fields in Part B are required.
Completing the General Medical Template
Continued (3 of 5)

C1. Enter the Provider’s nine (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 Provider's profile, it can be left blank. (Not Required)

C5. Confirm whether you are providing care for a family member.

C6. If the answer to C5 is Yes, enter your relationship to the claimant. (Only required if Yes is selected in C5)
Completing the General Medical Template
Continued (4 of 5)

D1. Enter up to four (4) ICD-9 or ICD-10 codes.

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

D2. Confirm whether this is an implant.

D3. If the answer to D2 is Yes, this is an implant, enter the cost of the implant.

D4. Select the place where 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 the Revenue Code type for Outpatient Facility services as per instructions.
- Enter the Revenue Code, if applicable.
- Enter the Procedure Code (CPT, HCPCS, or NDC).
- Enter the code Modifier, if applicable.
- Enter Units Requested.

D6. Enter any additional remarks.
Attach any supporting documentation that may help. (Not required)

**Important!** Be sure to include the Claimant’s Case ID on all additional pages submitted with the template.

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**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.
Home Health Services that are level 3 require the completion of the Home Health Template.
Completing the Home Health Template
Continued (1 of 5)

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).

**Note:** A correction cannot be submitted for Home Health Request in “processed-awaiting decision” status.

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)**
Completing the Home Health Template
Continued (2 of 5)

B1. Enter the Claimant’s nine (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.
C1. Enter the Provider’s nine (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 whether you are providing care for a family member.

C6. If the answer to C5 is Yes, enter your relationship to the claimant. (Only required if Yes is selected in C5)
D1. Select the Service Type (Assisted Living, HHC, Hospice, or Nursing Home).

D2. Enter up to four (4) ICD-9 or ICD-10 codes.

Note: ICD-9 code is applicable if date of service is on or prior to September 30, 2015. Use ICD-10 code if date of service is on or 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 the claimant will be seen).
- Enter the Duration (how many total weeks the claimant will be seen).
- Enter the Total Units Requested (Frequency x Duration = Total Units Requested).

D4. Enter any additional remarks
Include a 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 conditions.

**Important!** Be sure to include the Claimant’s Case ID on all additional pages submitted with the template.

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<table>
<thead>
<tr>
<th>PART E: Supporting Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
Rehabilitative Therapies Template
Providers rendering Physical Therapy, Occupational Therapy, Speech Therapy, Massage Therapy, or other Rehabilitative Therapies require the completion of a Rehabilitative Therapies Authorization Template.
Completing the Rehabilitative Therapies Template
Continued (2 of 5)

**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.** 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)*
Completing the Rehabilitative Therapies Template
Continued (3 of 5)

B1. Enter the Claimant’s nine (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.
C1. Enter the Provider’s nine (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 Provider’s profile, it can be left blank. (Not Required)
C5. Confirm whether you are providing care for a family member.
C6. If the answer to C5 is Yes, enter your relationship to the claimant. (Only required if Yes is selected in C5)
D1. Select a Place of Service (Home, Facility, Office, or Outpatient).

D2. Enter up to four (4) ICD-9 or ICD-10 codes.

**Note:** ICD-9 code is applicable if the date of service is on or prior to September 30, 2015. Use ICD-10 code if the date of service is on or 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 the claimant will be seen).
- Enter the Duration (how many total weeks the claimant will be seen).
- Enter the total units requested (# of Units Per Procedure x Frequency x Duration = Total Units Requested).

D4. Enter any additional remarks.
Transplant Template
Transplant Template, continued

Transplants require the completion of a DEEOIC Transplant Authorization Template.
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)*

<table>
<thead>
<tr>
<th></th>
<th>PART A: Requestor Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1. Date Requested:</td>
<td></td>
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<tr>
<td>A2. Requested By:</td>
<td></td>
</tr>
<tr>
<td>A3. Phone Number:</td>
<td></td>
</tr>
</tbody>
</table>
Completing the Transplant Template
Continued (2 of 7)

B1. Enter the Claimant’s nine (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.

<table>
<thead>
<tr>
<th>PART B: Claimant Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1. Claimant’s Case ID:</td>
</tr>
<tr>
<td>B2. Date of Birth:</td>
</tr>
<tr>
<td>B3. First Name:</td>
</tr>
<tr>
<td>B4. Last Name:</td>
</tr>
<tr>
<td>B5. Authorized Representative:</td>
</tr>
<tr>
<td>B6. Phone Number:</td>
</tr>
</tbody>
</table>

**Note:** All fields in Part B are required.
C1. Enter the Provider’s nine (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)**

<table>
<thead>
<tr>
<th>PART C: Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1. OWCP Provider ID:</td>
</tr>
<tr>
<td>C2. Tax ID (SSN/FEIN):</td>
</tr>
<tr>
<td>C3. Name:</td>
</tr>
<tr>
<td>C4. Fax Number:</td>
</tr>
</tbody>
</table>
D1. Enter the Treating Physician’s name.

D2. Enter the Treating Physician’s Address.
E1. Up to four (4) ICD-9 or ICD-10 codes can be entered.
   - ICD-9 code is applicable if date of service is on or prior to September 30, 2015. Use ICD-10 code if date of service is on or 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 an HCPCS or a CPT code.
   - Enter the Procedure Code.

E3. Enter any additional remarks.
Completing the Transplant Template
Continued (6 of 7)

F1. Enter the name of the Transplant Facility.
F2. Enter the type of Transplant being performed.
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 transplant coordinator’s Phone Number.

<table>
<thead>
<tr>
<th>PART F: Transplant Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1. Transplant Facility:</td>
</tr>
<tr>
<td>F3. Transplant Facility Address:</td>
</tr>
<tr>
<td>F4. Transplant Facility Phone:</td>
</tr>
<tr>
<td>F5. Organ Transplant Coordinator Name:</td>
</tr>
</tbody>
</table>

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All supporting documentation is required.

**Important!** Be sure to include the Claimant's Case ID on all additional pages submitted with the 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
Medical Transportation Template
Providers rendering the following travel services 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
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
Continued (2 of 5)

B1. Enter the Claimant’s nine (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.
C1. Enter the Provider’s nine (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 Provider’s profile, it can be left blank. **(Not Required)**

C5. Confirm whether you are providing care for a family member.

C6. If the answer to C5 is Yes, enter your relationship to the claimant. **(Only required if Yes is selected in C5)**
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.
Attach receipts or invoices to confirm the estimated total charge.

**Important!** Be sure to include the Claimant’s Case ID on all additional pages submitted with the template.

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**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.
Authorization Submission Methods

Authorization Templates can be submitted in the following ways:

- **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 one (1) business day of receipt.

To check on your Authorization status, visit the Office of Workers’ Compensation Programs, Medical Bill Processing Portal website (https://owcpmed.dol.gov) or contact a customer service representative by phone at 844-493-1966 beginning April 27, 2020.
THANK YOU
THANK YOU