DEEOIC Authorization Templates

Introduction

- Overview
- How to Complete the DEEOIC Authorization Templates :
 - Durable Medical Equipment (DME)
 - General Medical
 - Home Health
 - <u>Rehabilitative Therapies</u>
 - <u>Transplant</u>
 - Medical Transportation
- Authorization Submission Methods



Overview

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 <u>Office of Workers'</u> <u>Compensation Programs, Medical Bill Processing Portal (https://owcpmed.dol.gov)</u> or contact a customer service representative at 844-493-1966.

Durable Medical Equipment Template

Durable Medical Equipment Template, continued

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.

					PAR	T A: Request	or Information	n		
A1. Date F	Requested:									
A2. Reque	ested By:						A3. Phone I	Number:		
					PA	RT B: Claiman	t Information			
31. Claima	ant's Case ID	:					B2. Date of	Birth:		
33. First N	lame:						B4. Last Na	ime:		
					PA	RT C: Provide	r Information			
C1. OWCE	P Provider ID						C2. Tax ID	(SSN/FEIN):		
03. Name	E						C4. Fax Nu	mber:		
05. Provid	ding care for a	famil	y men	nber?:		•				
C6. If Yes	, please provi	de rela	ations	hip to t	e claimant:					
					PART	D: Service L	ine Informatio	on		
01. Diagn	osis Codes:			А.	PAR	D: Service L	ine Informatio	D.		
01. Diagn 02.	osis Codes:			A.	PAR	D: Service L 3.	c.	D.		
D1. Diagn D2. From Date	osis Codes:	Dia	gnosis	A.	PAR1 Code Type	D: Service Li B. Procedure Code	C.	D. D. Rental or Purchase Modifier	Cost	Duration
D1. Diagn D2. From Date	osis Codes: To Date	Dia Poli A	gnosis nter B (A. C D	Code Type	D: Service L 3. Procedure Code	C.	D. Rental or Purchase Modifier	Cost	Duration
01. Diagn 02. From Date	To Date	Dia Poli A	gnosis nter B	A. C D	Code Type	D: Service L 3. Procedure Code	C.	D. D. Rental or Purchase Modifier	Cost	Duration
D1. Diagn D2. From Date	To Date	Dia Poli	gnosis nter B	A. C D	Code Type	D: Service L 3. Procedure Code	C.	D. D. Modifier	Cost	Duration
D1. Diagn D2. From Date	To Date	Dia Poli	gnosis nter B	A. C D	Code Type	D: Service L 3. Procedure Code	C. Units	D. D. Modifier	Cost	Duration
D1. Diagn D2. From Date	To Date	Dia Poli	gnosis nter B	A. C D	Code Type	D: Service L 3. Procedure Code	C. Units	D. D. Modifier	Cost	Duration
D1. Diagn D2. From Date	To Date		gnosis hter B	A.	PART	D: Service Li 3. Procedure Code	C.	D. D. Modifier	Cost	Duration
D1. Diagn D2. From Date D3. Rema	To Date	Dia Poli	gnosis hter B	A.	PAR i Type	D: Service Li 3. Procedure Code	C.	D. D. Modifier	Cost	Duration
D1. Diagn D2. From Date Date	To Date	Dia Poli	gnosis nter B	A.	PAR i Type	D: Service L 3. Procedure Code	Ine Informatic	D. D. Modifier	Cost	Duration
D1. Diagn D2. From Date	To Date	Dia Poli	gnosis nter B	A. B C D	Code Type	D: Service L 3. Procedure Code	Ine Informatic	D. D. Modifier	Cost	Duration
D1. Diagn D2. From Date	rks:	Dia Poli A	gnosis ter B	A. B C D	PAR	D: Service L 3. Code	ine Informatic	D. D. Modifier	Cost	Duration
D1. Diagn D2. From Date	rks:	Dia Poli	gnosis ter B	A.	PAR	D: Service L 3. Procedure Code	ine Informatic	D. D. Modifier	Cost	Duration

DEEOIC Durable Medical Equipment Authorization Request

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)

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

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.

PART B: Claima	ant Information
B1. Claimant's Case ID:	B2. Date of Birth:
B3. First Name:	B4. 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)

PART C: Provid	er 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:	

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).

Note: Effective 08/05/23, an authorization cannot be submitted with the same procedure code on multiple lines even if the dates of service are not overlapping. The authorization will be RTPd. A new authorization must be submitted for each service date tied to the same procedure code. To submit all details in one (1) authorization, combine dates, amount, and units. The Modifier cannot be combined.

- 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).

						PA	RT	D: Service Lir	e Informatio	n		
1. Diagno	osis Codes:			A.			В	l.	C.	D.		
From Date	To Date	Dia Poi	gnos nter	sis		Code Type		Procedure Code	Units	Rental or Purchase Modifier	Cost	Duration
		A	в	с	D							
							•			<u>·</u>		
							•			•		
							•			•		
							•			-		
							•			•		
3. Rema	rks:											

General Medical Template

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.

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.

General Medical Template, continued

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

on all pages. In	complete rec	quests cannot	be processe	d and will be	returned.		
			PART A: I	Requestor I	nformation		
A1. Date Requ	ested:						
A2. Requested	By:			A3.	Phone Number:		
			PART B:	Claimant In	formation		
B1 Claimant's	Case ID:			82	Date of Birth:		
D1. Claiman 2	uase io.				Last Names		
B3. FIRSt Name			DARTO	D4.	Last Name:		
			PART C:	Provider in	formation		
C1. OWCP Pro	vider ID:			C2.	Tax ID (SSN/FEIN	I):	
C3. Name:				C4.	Fax Number:		
C5. Providing c	are for a fam	nily member?:		_			
C6. If Yes, plea	se provide re	elationship to t	he claimant				
	~			des Line	Information.		
D1 Diagnosis (Codes:	P	AKTU.S	ervice Line	niormation		
D2 Is this an in	rouce.	•	υ.		D2 Cort of	implant:	
D4. Place of Se	rvice (Select	tone)	Ambulatory Home	Surgery Cent	er (ASC)	inpan.	
			Office				
D5			Outpatient				
From Date	To Date	Diagnosis Pointer ABCD	Code Type	Revenue Code	Procedure Code	Modifier	Units/Days Request
			-				
D6. Remarks:							

DEFOIC General Medical Authorization Request

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)

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

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.

PART B: Claima	ant Information
B1. Claimant's Case ID:	B2. Date of Birth:
B3. First Name:	B4. Last Name:

Note: All fields in Part B are required.

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)

PART C: Provid	er 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:	

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).

Note: Effective 08/05/23, a general medication authorization cannot be submitted with the same revenue code on multiple lines without a different procedure code or with no procedure code even if the dates of service are not overlapping. The authorization will be RTPd. Submit a new authorization for each service date tied to the same revenue code. To submit all details in one (1) authorization, combine dates, amount, and units. The Modifier cannot be combined.

- Enter the code Modifier, if applicable.
- Enter Units Requested.

D6. Enter any additional remarks.

			PART D: S	ervice Line	Information		
D1. Diagnosis	Codes:	Α.	В.		C.	D.	
D2. Is this an ir	mplant?:	-			D3. Cost of	implant:	
D4. Place of S	ervice (Select	t one)	Ambulatory Home Office Outpatient	Surgery Cent	er (ASC)		
D5. From Date	To Date	Diagnosi	s Code	Revenue	Procedure	Modifier	Units/Days Request
Profit Date	To Date	Pointer	Type	Code	Code	mouner	Units/Days Nequest
				1			
D6. Remarks:	1			1	1		1

Continued (5 of 5)

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.

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 Template

Home Health Template, continued

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

					PART	A: Reques	tor Infe	ormation		
1. 📃 Initial	Request	Re Re	-Autho	orizatio	n	Amer	ndment		Correction	
2. Original Au	thorization Nu	mber (For	Corre	ction)	:					
.3. Date Requ	ested:									
4. Requested	By:						A5.	Phone Number	5	
					PAR	T B: Claima	int Info	rmation		
1. Claimant's	Case ID:						B2.	Date of Birth:		
3. First Name	¢						B4.	Last Name:		
					PAR	T C: Provid	er Info	rmation		
1. OWCP Pro	vider ID:						C2.	Tax ID (SSN/F	EIN):	
3 Name:							C4.	Fax Number:		
o. Hume.							1			
5. Providing o	are for a family	y member	?:			•	l			
5. Providing o 6. If Yes, plea	are for a family ase provide rela	y member ationship t	?: to the	claima	int:	-	I			
25. Providing o 26. If Yes, plea	are for a family se provide rela	y member ationship t	?: to the	claima P	ant: ART I	D: Service	Plan In	formation		
25. Providing o 26. If Yes, plea 11. Service Ty	care for a family ase provide rela pe:	y member ationship t	?: to the	claima P	ART I	D: Service	Plan In	formation		
25. Providing o 28. If Yes, plea 01. Service Ty 02. Diagnosis	eare for a family ase provide rela pe: Codes:	y member ationship t A.	?: to the	claima P	ant: ART I B.	D: Service	Plan In C.	formation		
 Providing c Providing c If Yes, pleating Service Ty Diagnosis Diagnosis Ecomp Data 	are for a family use provide rela pe: Codes:	y member ationship t A.	?: to the	claima P	ART I B.	D: Service	Plan In C.	formation D	Duration	Total Inite
25. Providing c 26. If Yes, plea 20. Service Ty 21. Diagnosis 22. Diagnosis 33. From Date	are for a family ise provide rela pe: Codes:	y member ationship t A. Diagr A	r: to the r nosis F B	claima P 	ART I B.	D: Service	Plan In C.	formation D Frequency	Duration	Total Units Request
25. Providing o 26. If Yes, plea 21. Service Ty 22. Diagnosis 33. From Date	are for a family ise provide rela pe: Codes: To Date	y member ationship t A. Diagr	realized for the state of the s	claima P Pointer C	ART I B.	D: Service	Plan In C.	formation D Frequency	Duration	Total Units Request
25. Providing o 26. If Yes, plea 11. Service Ty 12. Diagnosis 13. From Date	are for a family ase provide rela pe: Codes: To Date	A.	realized and the state of the s	claima P C	ART I	D: Service	Plan In C.	formation D Frequency	. Duration	Totai Unita Request
25. Providing c 26. If Yes, plea 11. Service Ty 12. Diagnosis 13. From Date	are for a family ase provide rela pe: Codes: To Date	A.	nosis F	elaima P C	ART I	D: Service	Plan In C.	formation	Duration	Totai Unite Request
25. Providing c 26. If Yes, plea 11. Service Ty 12. Diagnosis 13. From Date	are for a family asse provide rela- pe: Codes: To Date	A.	?: to the e	Pointer C	ART I	D: Service		formation	Duration	Totai Unite Request

Continued (1 of 5)

	PAR	T A: Requestor Informa	ation
A1. 🔲 Initial Request	Re-Authorization	Amendment	Correction
A2. Original Authorization N	umber (For Correction):		
A3. Date Requested:			
A4. Requested By:		A5. Pho	one 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).

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)

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.

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

Note: All fields in Part B are required.

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 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)

PART C: Provid	er 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:	

Continued (4 of 5)

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 Procedure Code from the available options.

Note: Effective 08/05/23, an authorization cannot be submitted with the same procedure code on multiple lines even if the dates of service are not overlapping. The authorization will be RTPd. A new authorization must be submitted for each service date tied to the same procedure code. To submit all details in one (1) authorization, combine dates, amount, and units. The Modifier cannot be combined.

- 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

rom Date	To Date	Diagr	10sis F	ointer		Procedure		Frequency	Duration	Total Units
		А	в	с	D	Code				Request
							•			
							•			
							•			
							•			
							•			
Remarks:										

Continued (5 of 5)

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.

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.

Rehabilitative Therapies Template

Rehabilitative Therapies Template, continued

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

Processing Portal (http be processed and will b	s://owcpr	<u>ned.dol.g</u> ed	ov). Please in	clude the DEEC	DIC Claimant Case	e ID on all page	s. Incomplete	requests can
			PAR	T A: Requesto	or Information			
A1. 📃 Initial Reques	at 📃 Re	e-Authori	zation 📃 A	mendment	Correction			
A2. Original Authorizati	on Numb	er (For C	orrection):					
A3. Date Requested:								
A4. Requested By:					A5. Phone Numb	ber:		
			PA	RT B: Claimant	t Information			
B1. Claimant's Case ID	t:				B2. Date of Birth	c		
33. First Name:					B4. Last Name:			
			PA	RT C: Provider	Information			
C1. OWCP Provider ID	:				C2. Tax ID (SSN	I/FEIN):		
C3. Name:					C4. Fax Number	с		
C5. Providing care for a	a family m	nember?:		-				
C6. If Yes, please prov	ide relatio	onship to	the claimant:					
		<u>.</u>		0.4				
Home D2. Diagnosis Codes:	_ Facilit	A.	Office	B.	C.	D.		
Home D2. Diagnosis Codes:	Diagno Pointe	A.	Code Type	B. Procedure Code	C. # of units per procedure/visit	D.	Duration	Total units requested
D2. Diagnosis Codes: D3. From To Date	Diagno Pointe A B	A. 2618 r C D	Code Type	B. Procedure Code	C. # of units per procedure/visit	D.	Duration	Total units requested
Home Home 22. Diagnosis Codes:	Diagno Pointei A B	A.	Code Type	B. Procedure Code	C.	D.	Duration	Total units requested
Home Home 22. Diagnosis Codes: 03. From To Date Date	Diagno Pointei A B	A.	Code Type	Procedure Code	C.	D.	Duration	Total units requested
Home Home Home D2. Diagnosis Codes: D3. From Date D	Diagno Pointe A B	A.	Code Type	B. Procedure Code	C.	D.	Duration	Total units requested
Home D2. Diagnosis Codes:	Diagno Pointe A B	A.	Code Type	B. Procedure Code	C.	D.	Duration	Total uni requester

Continued (2 of 5)

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.** 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)

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.

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

Note: All fields in Part B are required.

Continued (4 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)

PART C: Provid	der 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:	

Continued (5 of 5)

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 Procedure Code from the available options.

Note: Effective 08/05/23, an authorization cannot be submitted with the same procedure code on multiple lines even if the dates of service are not overlapping. The authorization will be RTPd. A new authorization must be submitted for each service date tied to the same procedure code. To submit all details in one (1) authorization, combine dates, amount, and units. The Modifier cannot be combined.

- 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.

D1. Place of Second	ervice (Se	lect o		PART D: Therapy Plan Information								
Hom			one)									
	·• _	Fa	cility			Office		Outpatie	ent			
02. Diagnosis	Codes:			A.				В.	C.	D.		
03.												
From T Date	o Date	Diag Poir	jnos nter	is		Code Type		Procedure Code	# of units per procedure/visit	Frequency	Duration	Total units requested
		Α	в	с	D							
							•					
							-					
							•					
							•					
							•					

Transplant Template

Transplant Template, continued

Transplants require the completion of a DEEOIC Transplant Authorization Template.

Please read the instructions carefully before cor requests with supporting documentation must elit Processing Portal (<u>https://wwomed.dol.gov</u>). Plea processed and will be returned.	mpleting authorization her be faxed with the ase include the DEE(on request. (is template o DIC Claiman	Complete all ap or its equivalent t Case ID on all	plicable f or be su pages. In	fields. All Prior Authorization brnitted through the Web Bill complete requests cannot be	
	PART A: Request	or Informati	ion			
A1. Date Requested:						
A2. Requested By:		A3. Phone Number:				
	PART B: Claimar	nt Informatio	on			
B1. Claimant's Case ID:		B2. Date of Birth:				
B3. First Name:		B4. Last Name:				
B5. Authorized Representative:		B6. Phon	e Number:			
	PART C: Provide	r Informatio	n			
C1. OWCP Provider ID:		C2. Tax I	D (SSN/FEIN):			
C3. Name:		C4. Fax N	lumber:			
PA	RT D: Treating Phy	sician Infor	mation			
D1. Treating Physician:						
D2. Treating Physician Address:						
	PART E: Service L	ine Informa	tion			
E1. Diagnosis Codes: A.	В.	C.		D.		
E2.						
From Date D	lagnosis Pointer		Code Type		Procedure Code	
	A B C	D				
				-		
				-		
				-		
				_		
E3. Remarks:	DADT E. Transala					
Ed. Tennedent Facility	FARTE. Transpla	nt mormau	on .			
F 1. Transplant Facility.		F2. Trans	piant Type:			
Ed: Transplant Facility Aburess.						
F4. Transplant Facility Phone.			Munitive			
Po. Organ Transplant Coordinator Name.		FU. FIION	e Number.			
All supporting documents must be attached to the processing or denial. See instructions for required	PART G: Supporti request. Failure to i documents. Please	ng Docume nclude supp ensure to in	nts orting documen clude claimant's	tation ma s case ID	y result in a delay in on each page.	
Required documentation:						
Letter of medical necessity from the treat	ting physician descri	bing the nee	d for the transp	ant being	requested.	
Initial and recent clinical evaluation (i.e.,	diagnostic studies a	nd laborator	y tests)			
A copy of the treatment protocol						

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

- **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)

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

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.

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:						

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)**

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

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:

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.

Note: Effective 08/05/23, an authorization cannot be submitted with the same procedure code on multiple lines even if the dates of service are not overlapping. The authorization will be RTPd. A new authorization must be submitted for each service date tied to the same procedure code. To submit all details in one (1) authorization, combine dates, amount, and units. The Modifier cannot be combined.

- Enter the Procedure Code.
- **E3.** Enter any additional remarks.

rom Date	To Date	Diagnos	sis Pointe	r		Code Type	Procedure Code
		Α	в	с	D		
						•	
						•	
						•	
						•	
						•	

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.

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:				

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 s proc	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.				
Rec	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

Medical Transportation Template, continued

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

Please read the instructio	ns carefully before co	mpleting auth	orization request. Co	omplete all applicable fields. Al	
Authorization requests with	th supporting docume	entation must	either be faxed with	this template or its equivalent	
submitted through the We	b Bill Processing Porta	l (https://owcj	pmed.dol.gov). Pleas	e include the DEEOIC Claimant C	
on all pages. Incomplete re	equests cannot be pro	cessed and wil	l be returned.		
	PART	A: Request	or Information		
A1. Date Requested:					
A2. Requested By:			A3. Phone Number:		
	PAR	T B: Claimar	t Information		
B1. Claimant's Case ID:			B2. Date of Birth:		
B3. First Name:			B4. Last Name:		
	PAR	T C: Provide	r Information		
C1. OWCP Provider ID:			C2. Tax ID (SSN/FEI	N):	
C1. OWCP Provider ID:			C2. Tax ID (SSN/FEIN):		
_					
C3. Name:			C4. Fax Number:		
C3. Name:	nilv member?:	_	C4. Fax Number:		
C3. Name: C5. Providing care for a far	mily member?:	_	C4. Fax Number:		
C3. Name: C5. Providing care for a far C8. If Yes, please provide r	mily member?: relationship to the clair	 mant:	C4. Fax Number:		
C3. Name: C5. Providing care for a far C8. If Yes, please provide r	mily member?:	mant:	C4. Fax Number:		
C3. Name: C5. Providing care for a far C8. If Yes, please provide i	mily member?: relationship to the clain PART D	mant:	C4. Fax Number:		
C3. Name: C5. Providing care for a far C8. If Yes, please provide r D1. Transportation From:	mily member?: relationship to the clain PART D	mant:	C4. Fax Number: tion Information	x	
C3. Name: C5. Providing care for a fax C6. If Yes, please provide (mily member?: relationship to the clain PART D	mant:	C4. Fax Number: tion Information	x	
C3. Name: C5. Providing care for a fai C6. If Yes, please provide i D1. Transportation From: D3. From Date	mily member?: relationship to the clain PART D To Date	mant:	C4. Fax Number: tion Information D2. Transportation To ortation Code	: Estimated Total Charge	
C3. Name: C5. Providing care for a fai C6. If Yes, please provide D1. Transportation From: D3. From Date	mily member?: relationship to the clain PART D To Date	mant: : Transporta	C4. Fax Number: tion Information D2. Transportation To ortation Code	Estimated Total Charge	
C3. Name: C5. Providing care for a fai C6. If Yes, please provide i D1. Transportation From: D3. From Date	mily member?: relationship to the clain PART D To Date	mant:	C4. Fax Number: tion Information 22. Transportation To ortation Code	x Estimated Total Charge	
C3. Name: C5. Providing care for a far C6. If Yes, please provide (D1. Transportation From: D3. From Date	mily member?: relationship to the clain PART D To Date	mant:	C4. Fax Number: tion Information D2. Transportation To ortation Code	x Estimated Total Charge	
C3. Name: C5. Providing care for a fai C6. If Yes, please provide i D1. Transportation From: D3. From Date	mily member?: relationship to the clain PART D To Date	mant Transporta	C4. Fax Number: tion Information D2. Transportation To ortation Code v v v v v	2: Estimated Total Charge	
C3. Name: C5. Providing care for a fai C6. If Yes, please provide (D1. Transportation From: D3. From Date	mily member?: relationship to the clain PART D To Date	mant:	C4. Fax Number: tion Information D2. Transportation To ortation Code V V V V	Estimated Total Charge	
C3. Name: C5. Providing care for a fai C6. If Yes, please provide D1. Transportation From: D3. From Date D4. Remarks:	mily member?: relationship to the clain PART D To Date	Transporta	C4. Fax Number: tion Information 22. Transportation To ortation Code	2: Estimated Total Charge	
C3. Name: C5. Providing care for a far C6. If Yes, please provide D1. Transportation From: D3. From Date D4. Remarks:	mily member?: relationship to the clain PART D To Date	er Transportation	C4. Fax Number: tion Information D2. Transportation To ortation Code v v v	Estimated Total Charge	
C3. Name: C5. Providing care for a fai C6. If Yes, please provide D1. Transportation From: D3. From Date D4. Remarks:	mily member?: relationship to the clain PART D To Date	Transporta	C4. Fax Number: tion Information D2. Transportation To ortation Code	: Estimated Total Charge	
C3. Name: C5. Providing care for a fai C6. If Yes, please provide D1. Transportation From: D3. From Date D4. Remarks:	mily member?: relationship to the clain PART D To Date	Transporta	C4. Fax Number:	Estimated Total Charge	
C3. Name: C5. Providing care for a far C6. If Yes, please provide D1. Transportation From: D3. From Date D4. Remarks:	mily member?: relationship to the clain PART D To Date	Transporta	C4. Fax Number: tion Information D2. Transportation To ortation Code • • • • • •	Estimated Total Charge	

- **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)

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

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.

PART B: Claimant Information				
B1. Claimant's Case ID:	B2. Date of Birth:			
B3. First Name:	B4. 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)

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:					

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).
- Note: Effective 08/05/23, an authorization cannot be submitted with the same transportation code on multiple lines even if the dates of service are not overlapping. The authorization will be RTPd. Submit a new authorization for each service date tied to the same procedure code. To submit all details in one (1) authorization, combine dates, amount, and units.
- Enter the Estimated Total Charge amount.
- **D4.** Enter any additional remarks.

	PART D	: Transportation Information	
D1. Transportation From: D3.		D2. Transportation To:	·
From Date	To Date	Transportation Code	Estimated Total Charge
		<u> </u>	
D4. 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.

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 <u>Office of Workers'</u> <u>Compensation Programs, Medical Bill Processing Portal website</u> (<u>https://owcpmed.dol.gov</u>) or contact a customer service representative by phone at 844-493-1966 beginning April 27, 2020.



