DEEOIC Authorization Templates

Introduction

- Overview
- How to Complete the DEEOIC Authorization Templates :
  - Durable Medical Equipment (DME)
  - General Medical
  - Home Health
  - Rehabilitative Therapies
  - Transplant
  - 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 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

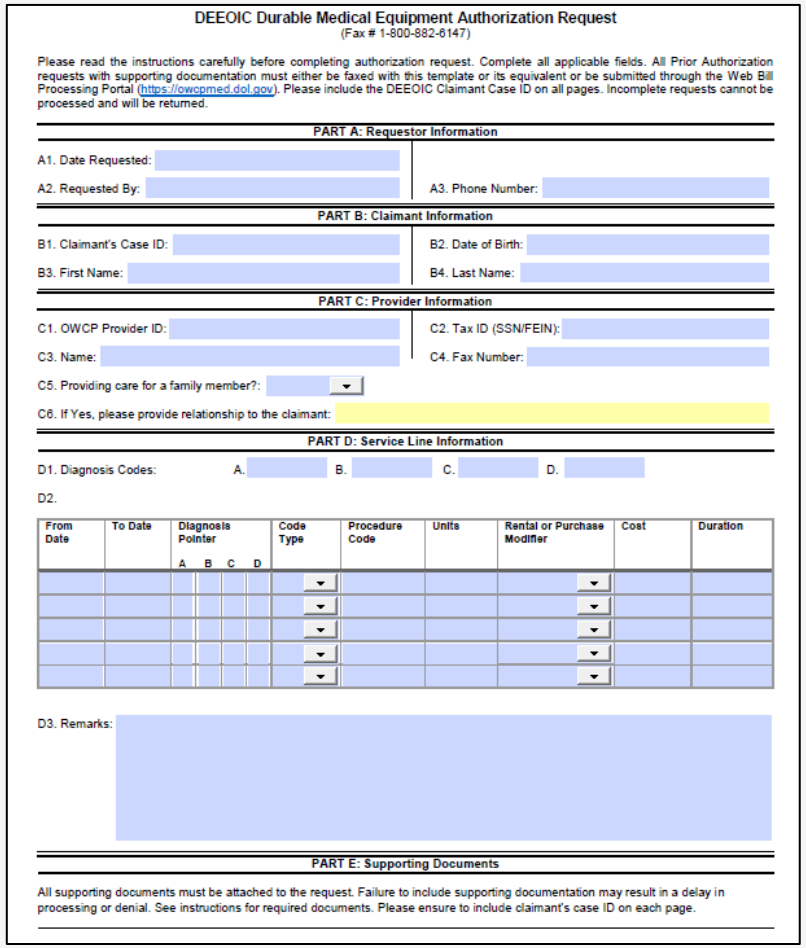
Durable Medical Equipment Template, continued

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.



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

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

Completing the Durable Medical Equipment 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.

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.

Completing the Durable Medical Equipment Template

Continued (3 of 5)

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

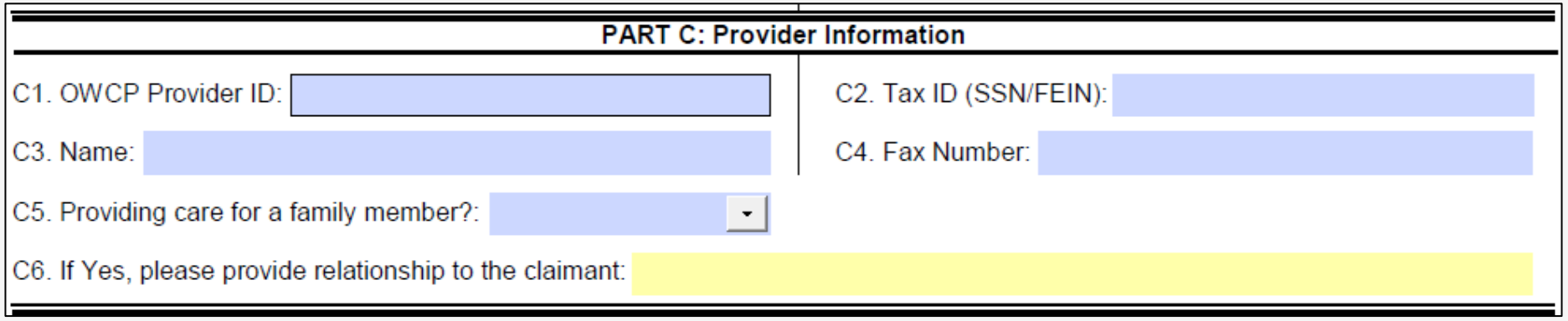
C2. Enter the Provider's Social Security Number (SSN) **or** Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in **C1**.

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 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.

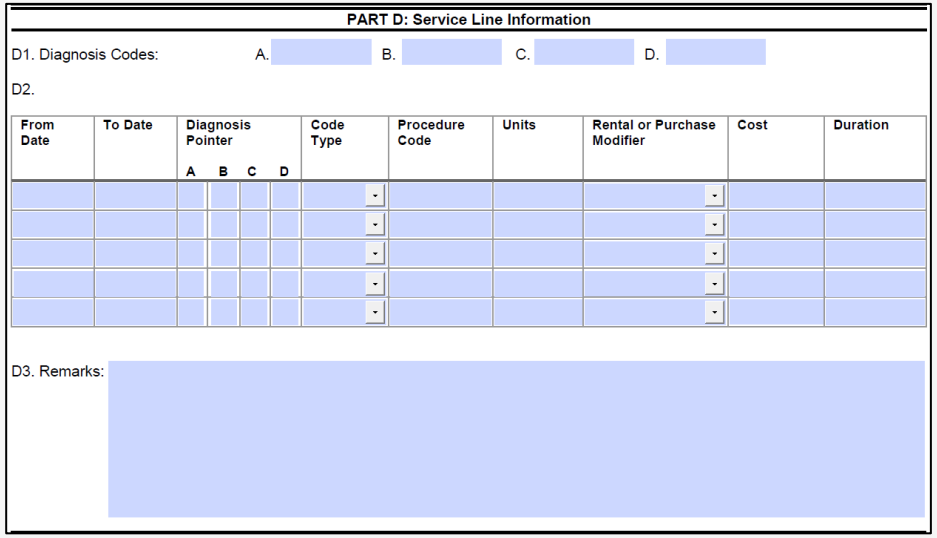
D2.

- 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).

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)**.



General Medical Template

Completing the Durable Medical Equipment Template

Continued (5 of 5)

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

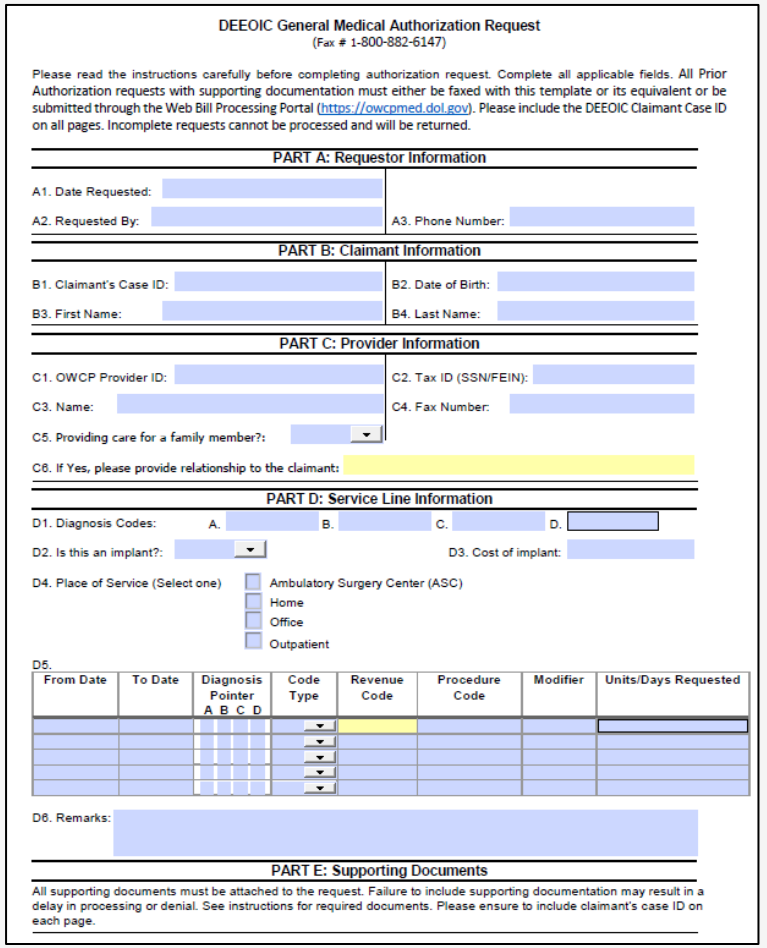
Important! Be sure to include the Claimant's Case ID on all additional pages submitted with the template.

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.



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.

Completing the General Medical 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)**

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

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.

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.

Completing the General Medical Template

Continued (3 of 5)

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

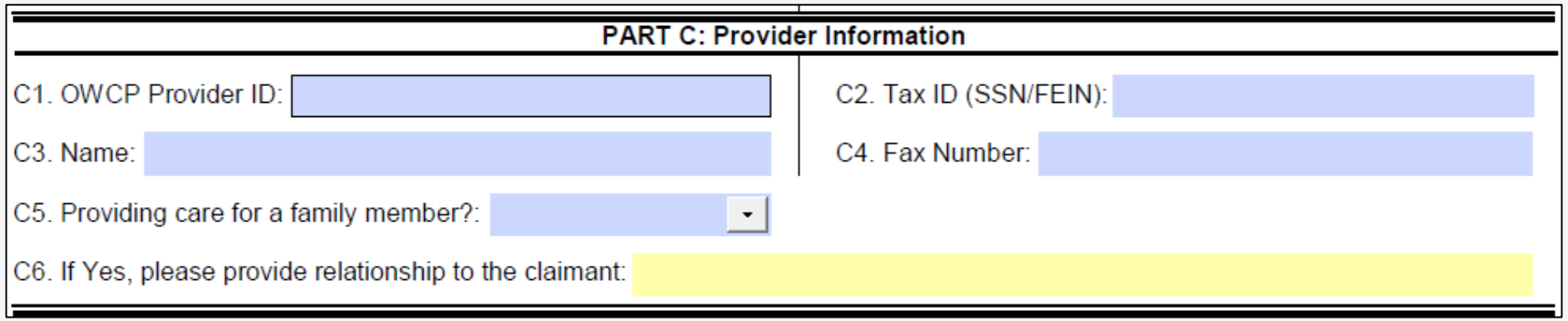
C2. Enter the Provider's Social Security Number (SSN) **or** Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in **C1**.

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.

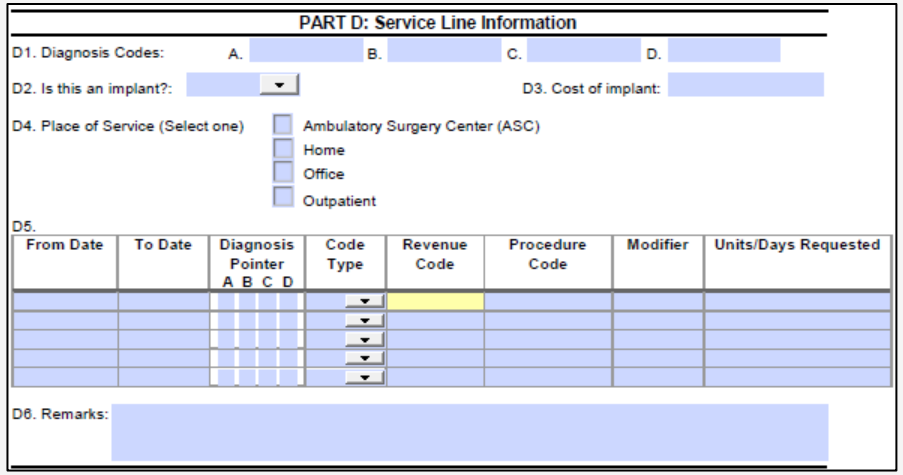
D4. Select the place where service was rendered.

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).



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.

Completing the General Medical Template

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.

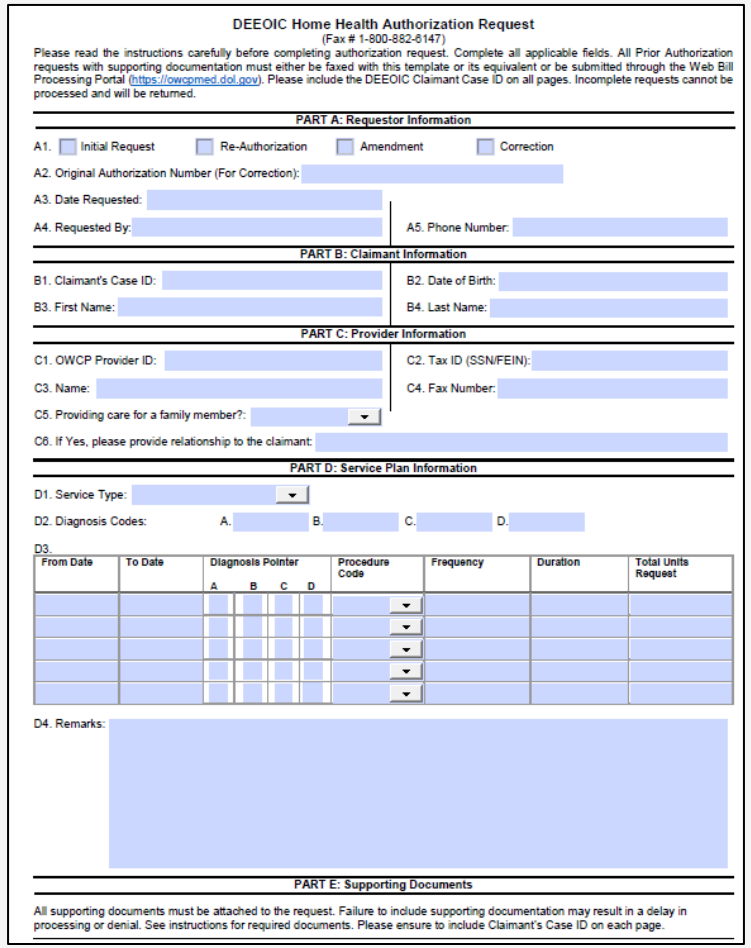
PART E: Supporting Documents

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.



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

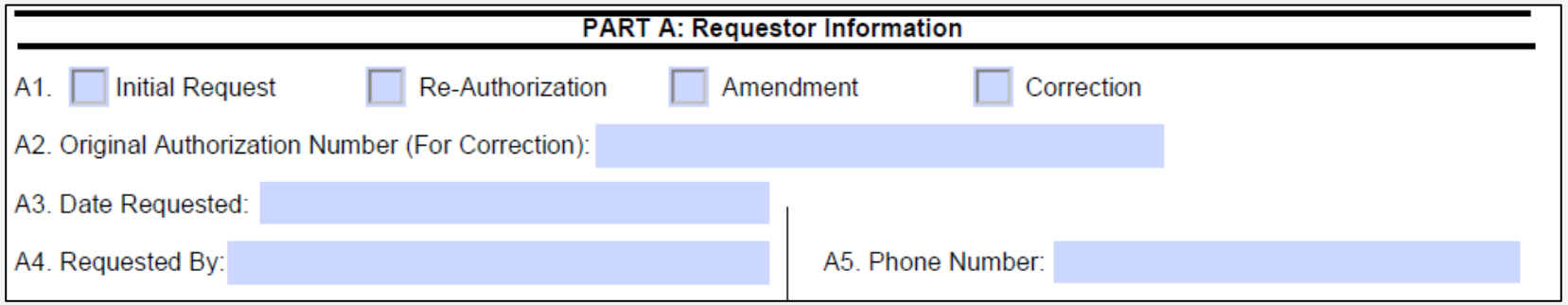
D4. Remarks:

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.

Completing the Home Health Template

Continued (1 of 5)


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).

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.

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.

Completing the Home Health Template

Continued (3 of 5)

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

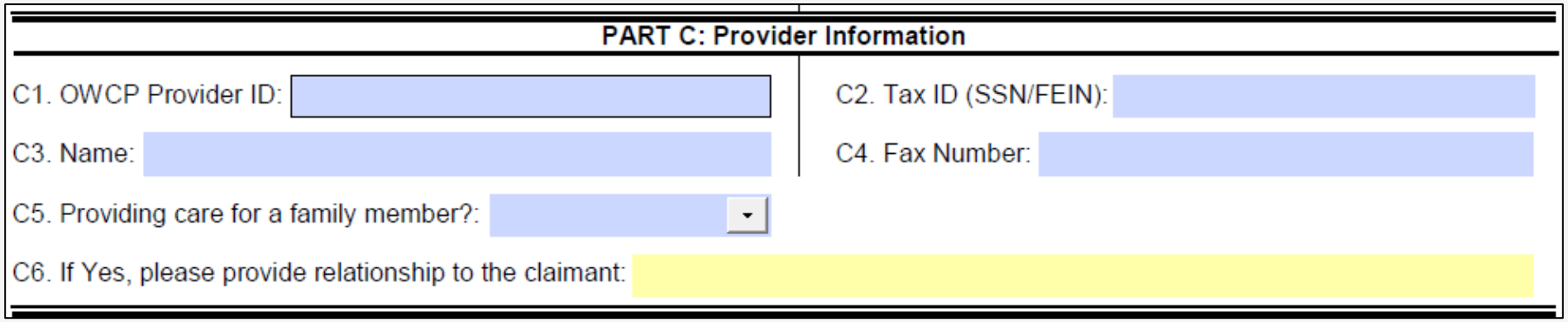
C2. Enter the Provider's Social Security Number (SSN) **or** Federal Employer Identification Number (FEIN) that is associated with the Provider ID in **C1**.

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 Home Health Template

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

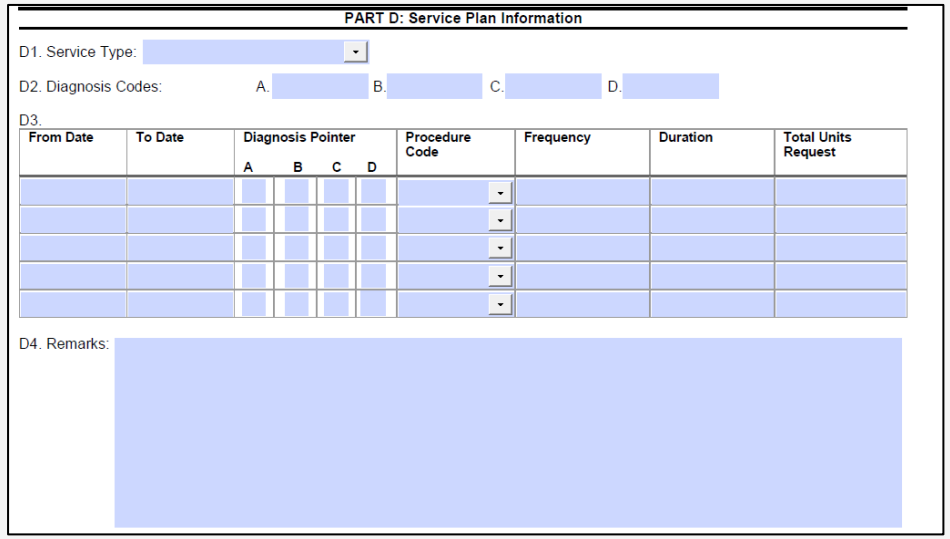
D3.

- 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


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:

Completing the Home Health Template

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.

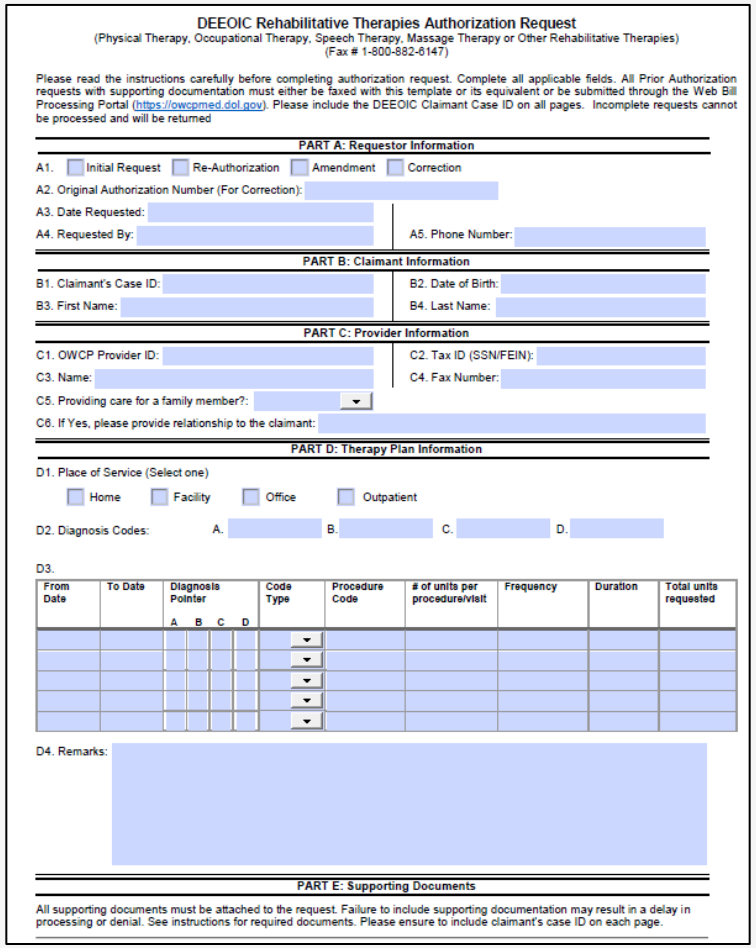
PART E: Supporting Documents

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.



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 A B C D	Code Type	Procedure Code	# of units per procedure/visit	Frequency	Duration	Total units requested

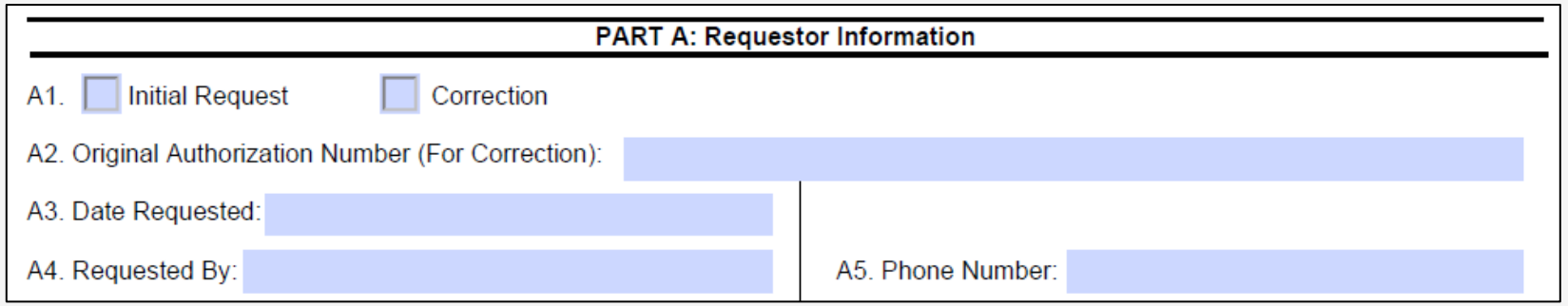
D4. Remarks:

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

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)**

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.

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.

Completing the Rehabilitative Therapies Template

Continued (4 of 5)

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

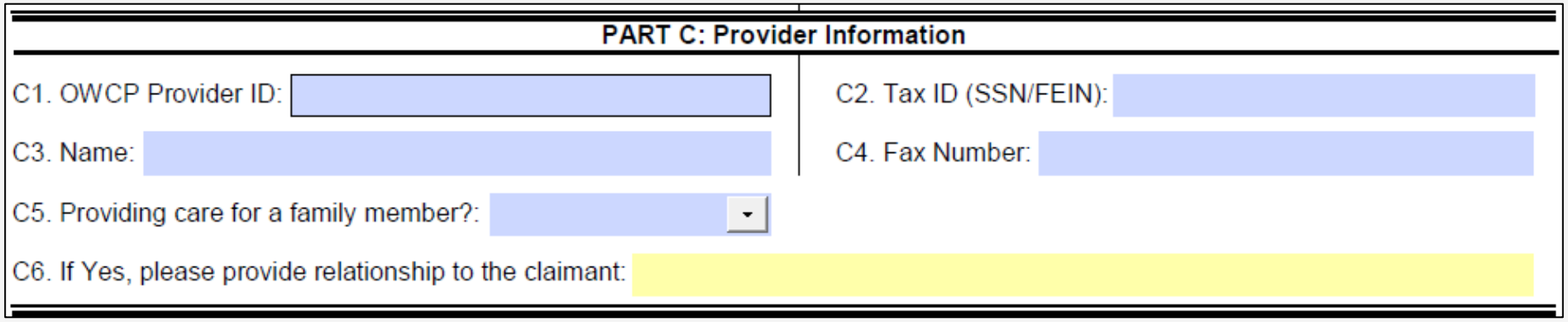
C2. Enter the Provider's Social Security Number (SSN) **or** Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in **C1**.

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)**



Completing the Rehabilitative Therapies Template

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.

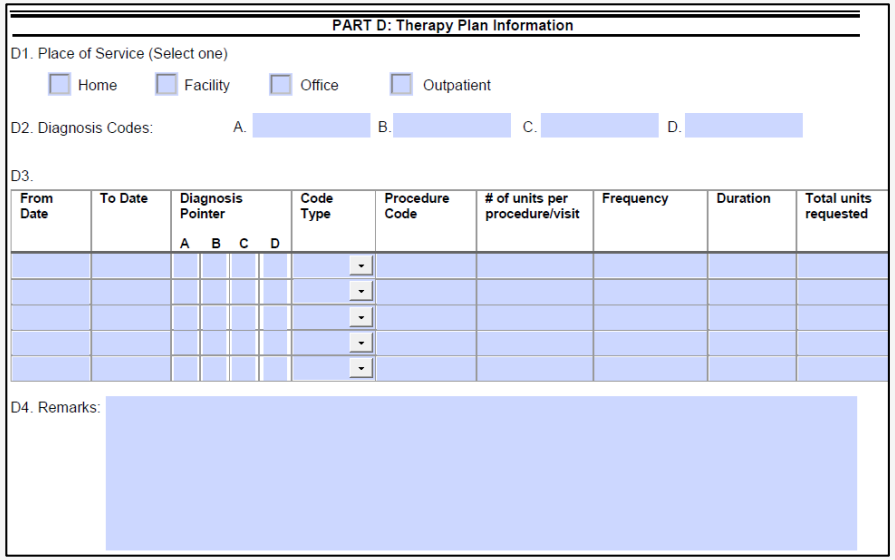
D3.

- 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.


PART D: Therapy Plan Information

D1. Place of Service (Select one)

Home Facility Office Outpatient

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

D3.

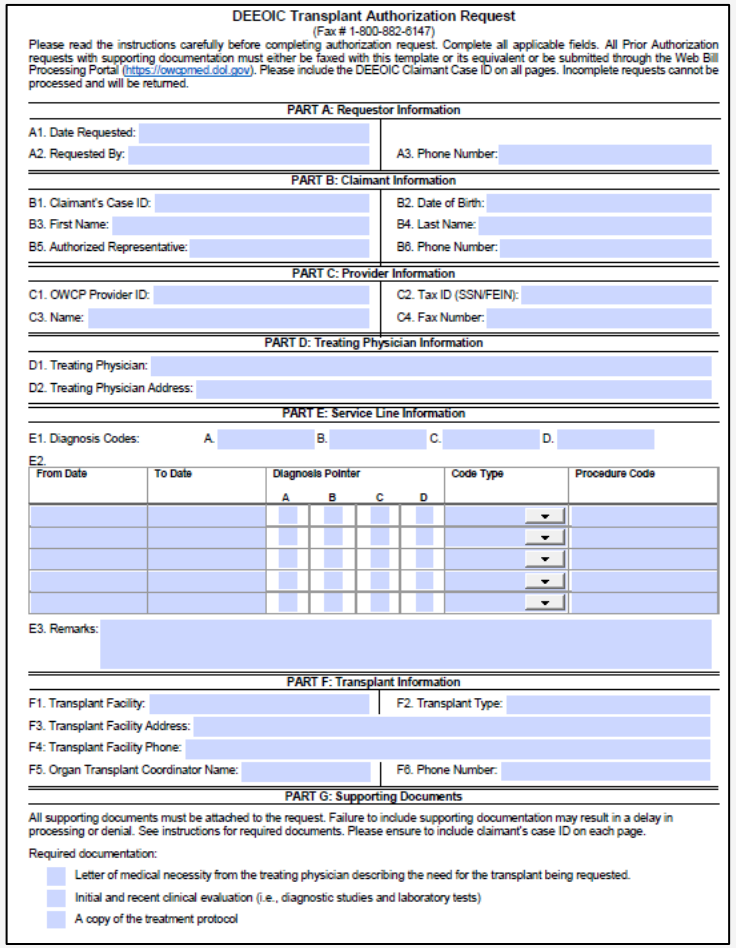
From Date	To Date	Diagnosis Pointer A B C D	Code Type	Procedure Code	# of units per procedure/visit	Frequency	Duration	Total units requested

D4. Remarks:

Transplant Template

Transplant Template, continued

Transplants 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 A	B	C	D	Code Type	Procedure Code

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

Completing the Transplant Template

Continued (1 of 7)

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:

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.

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.

Completing the Transplant Template

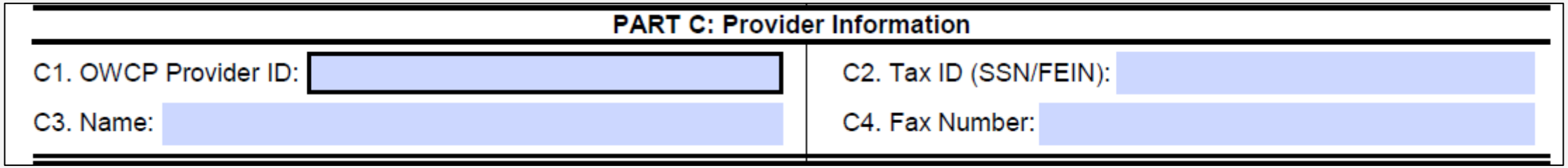
Continued (3 of 7)

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)**



Completing the Transplant Template

Continued (4 of 7)

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:	

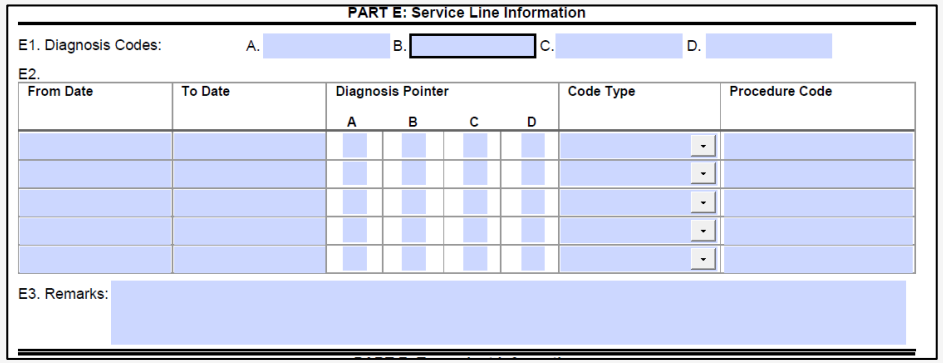
Completing the Transplant Template

Continued (5 of 7)

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.

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.

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:	

Completing the Transplant Template

Continued (7 of 7)

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:

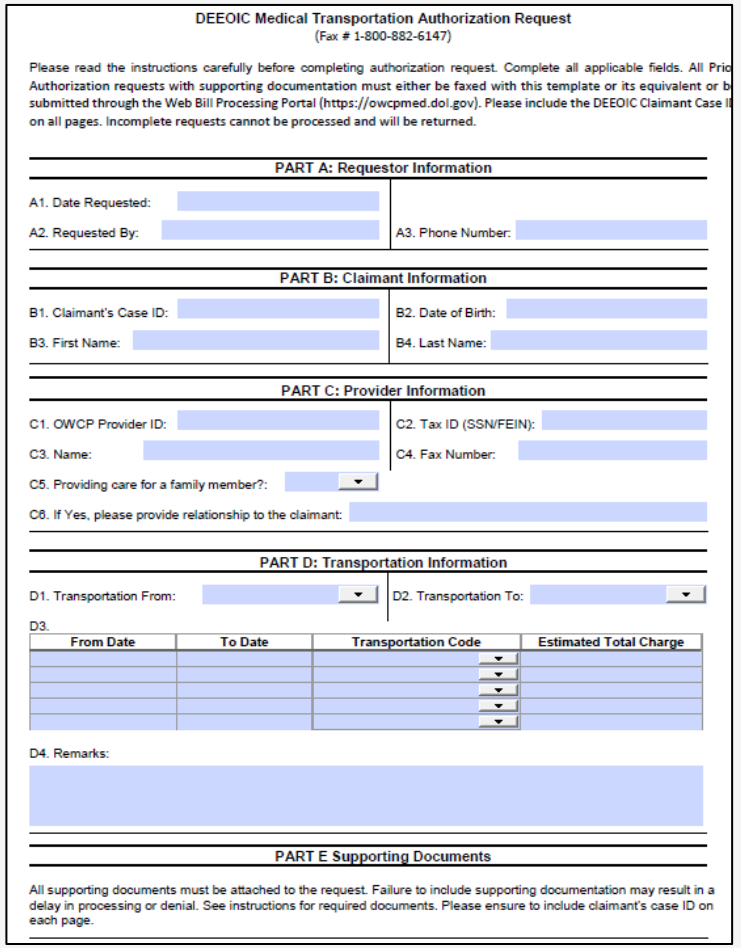
- ☐ Letter of medical necessity from the treating physician describing the need for the transplant being requested.
- ☐ Initial and recent clinical evaluation (i.e., diagnostic studies and laboratory tests)
- ☐ A copy of the treatment protocol

Medical Transportation Template

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



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

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

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.

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.

Completing the Travel Template

Continued (3 of 5)

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

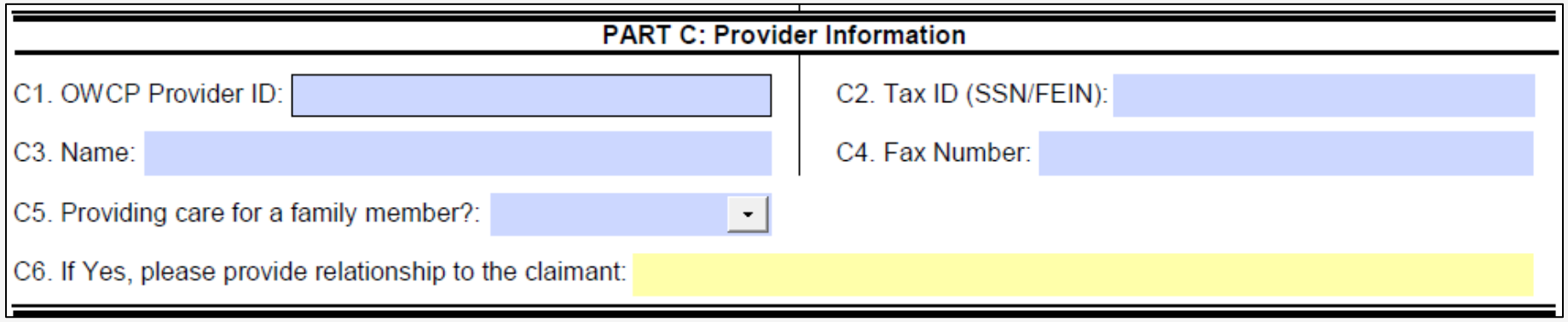
C2. Enter the Provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in **C1**.

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 Travel Template

Continued (4 of 5)

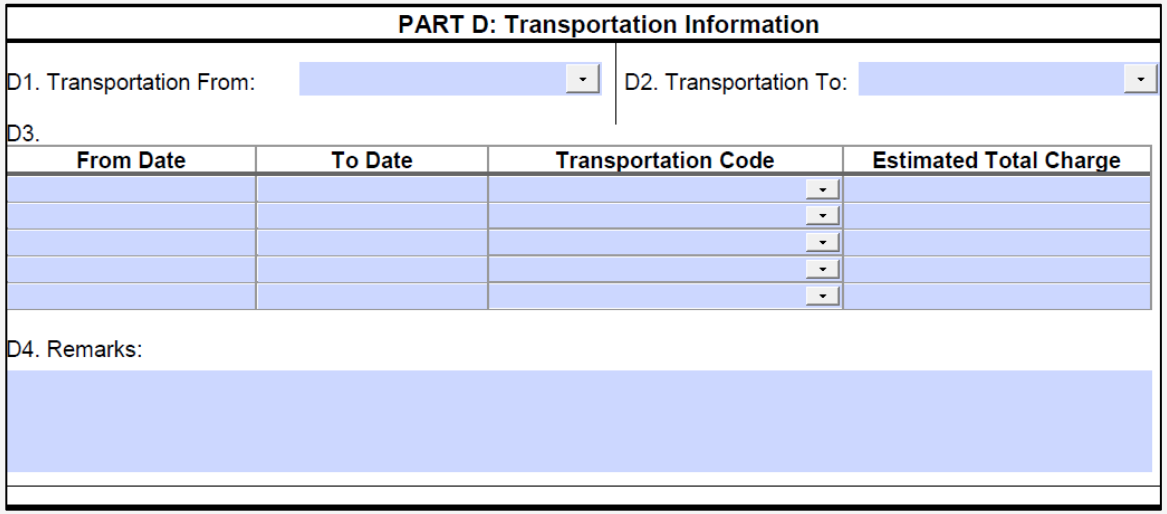
D1. Select the location where your travel started from.

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.

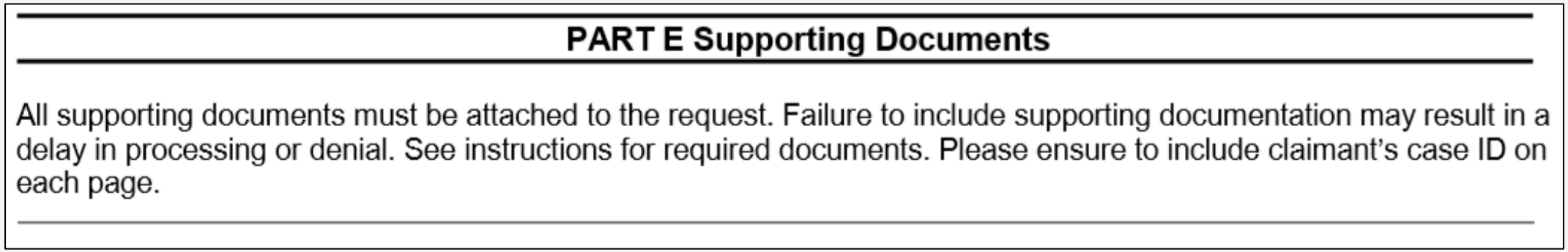


Completing the Travel Template

Continued (5 of 5)

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 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