

DFEC Authorization Templates



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Overview

When claimants are treated for their work-related injuries and/or occupational diseases, providers are required to secure an approved prior authorization for certain services. DFEC provides the prior authorization request templates for Provider use when requesting prior authorization. These templates were recently updated and on the WCMBP web portal on the References page under the Resources Menu.

Providers are able to determine whether a service requires a prior authorization by using the Claimant Eligibility feature available within the WCMBP System's Provider Portal @ <https://owcpmed.dol.gov> or you may speak with a customer service representative @ 844-493-1966.

Durable Medical Equipment Template



Durable Medical Equipment Template

Requests for Durable Medical Equipment that are a level 2 or 3 will require the completion of a DME Authorization Template.

DFEC Durable Medical Equipment Authorization Request
(Fax # 1-800-215-4901)

Please read the instructions carefully before completing authorization request. Complete all applicable fields. All Prior Authorization requests must either be faxed on this template or be submitted through the Web Bill Processing Portal (<https://owcpmed.dol.gov>). Fax with supporting medical documentation, including the Claimant ID on all pages. Incomplete requests cannot be processed and will be returned.

PART A: Requestor Information

A1. Initial Request Correction

A2. Original Authorization Number (For Correction): _____

A3. Date Requested: _____

A4. Requested By: _____

A5. Phone Number: _____

PART B: Claimant Information

B1. Claimant's Case ID: _____

B2. Date of Birth: _____

B3. First Name: _____

B4. Last Name: _____

B5. Date of Injury: _____

PART C: Provider Information

C1. OWCP Provider ID: _____

C2. Tax ID (SSN/FEIN): _____

C3. Name: _____

C4. Fax Number: _____

C5. Providing care for a family member?:

C6. If Yes, please provide relationship to the claimant: _____

PART D: Service Line Information

D1. Specific Body Part to be treated: _____

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

D3.

From Date	To Date	Diagnosis Pointer				Code Type	Procedure Code	Body Part Modifier	Units	Rental or Purchase Modifier	Cost	Duration
		A	B	C	D							

D4. Remarks: _____

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Completing the Durable Medical Equipment Template

PART A: Requestor Information	
A1. <input type="checkbox"/> Initial Request	<input type="checkbox"/> Correction
A2. Original Authorization Number (For Correction):	<input type="text"/>
A3. Date Requested:	<input type="text"/>
A4. Requested By:	A5. Phone Number: <input type="text"/>

A1. Select an option:

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

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

A3. Type the date the authorization is being completed.

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

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

Completing the Durable Medical Equipment Template

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

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

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

B5. Enter the Claimant's Date of Injury (mm/dd/yyyy).

Note: All fields in Part B are required.

PART B: Claimant Information	
B1. Claimant's Case ID: <input type="text"/>	B2. Date of Birth: <input type="text"/>
B3. First Name: <input type="text"/>	B4. Last Name: <input type="text"/>
B5. Date of Injury: <input type="text"/>	

Completing the Durable Medical Equipment Template

PART C: Provider Information	
C1. OWCP Provider ID: <input type="text"/>	C2. Tax ID (SSN/FEIN): <input type="text"/>
C3. Name: <input type="text"/>	C4. Fax Number: <input type="text"/>
C5. Providing care for a family member?: <input type="text"/>	
C6. If Yes, please provide relationship to the claimant: <input type="text"/>	

- C1.** Enter the provider's 9-digit OWCP Provider Identification Number (PIN).
- C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.
- C3.** Enter the Provider's Name.
- C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the providers profile, it can be left blank. (Not Required)
- C5.** Confirm if you are providing care for a family member or not.
- C6.** If you are providing care, state your relationship to the claimant. **(Only required if "Yes" was selected in C5.)**

Completing the Durable Medical Equipment Template

PART D: Service Line Information												
D1. Specific Body Part to be treated: <input type="text"/>												
D2. Diagnosis Codes: A. <input type="text"/> B. <input type="text"/> C. <input type="text"/> D. <input type="text"/>												
D3.												
From Date	To Date	Diagnosis Pointer				Code Type	Procedure Code	Body Part Modifier	Units	Rental or Purchase Modifier	Cost	Duration
		A	B	C	D							
D4. Remarks: <input type="text"/>												

D1. Enter the specific body part the DME is for.

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

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

D3.

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Enter the Code Type (HCPCS or CPT).
- Enter the Procedure Code (HCPCS).
- Select a Body Part Modifier option: LT(Left), RT(Right) or 50(Bilateral). Select 50 if the equipment is for the back, neck or head area.
- Enter the Units requested.
- Select RR (for Rental), NU (for Purchased New) or EU (for Purchased Used).
- Enter the total cost for the full DOS range.
- Enter duration. **(Required For Rentals Only)**

D4. Enter any additional notes you may have. (Not Required)

Completing the Durable Medical Equipment Template

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

A prescription from the prescribing doctor is required, along with the treatment plan.

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

General Medical Template



General Medical Template

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

DFEC General Medical Authorization Request
(Fax # 1-800-215-4901)

Please read the instructions carefully before completing authorization request. Complete all applicable fields. All Prior Authorization requests must either be faxed on this template or be submitted through the Web Bill Processing Portal (<https://owcpcmed.dol.gov>). Fax with supporting medical documentation, including the case file number on all pages. Incomplete requests cannot be processed and will be returned.

PART A: Requestor Information

A1. Initial Request Correction

A2. Original Authorization Number (For Correction): _____

A3. Date Requested: _____

A4. Requested By: _____ A5. Phone Number: _____

PART B: Claimant Information

B1. Claimant's Case ID: _____ B2. Date of Birth: _____

B3. First Name: _____ B4. Last Name: _____

B5. Date of Injury: _____

PART C: Provider Information

C1. OWCP Provider ID: _____ C2. Tax ID (SSN/FEIN): _____

C3. Name: _____ C4. Fax Number: _____

C5. Providing care for a family member? Yes No

C6. If Yes, please provide relationship to the claimant: _____

PART D: Service Line Information

D1. Specific Body Part to be treated: _____

D2. Is this a second surgery on the same body part?: Yes No

D3. Diagnosis Codes: A. _____ B. _____ C. _____ D. _____

D4. Is this an implant?: Yes No D5. Cost of implant: _____

D6.

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

D7. Remarks: _____

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Completing the General Medical Template

PART A: Requestor Information

A1. Initial Request Correction

A2. Original Authorization Number (For Correction):

A3. Date Requested:

A4. Requested By: A5. Phone Number:

A1. Select an option:

- Initial Request (new or first time requesting an authorization for general medical).
- 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 General Medical Template

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

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

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

B5. Enter the Claimant's Date of Injury (mm/dd/yyyy).

Note: All fields in Part B are required.

PART B: Claimant Information	
B1. Claimant's Case ID: <input type="text"/>	B2. Date of Birth: <input type="text"/>
B3. First Name: <input type="text"/>	B4. Last Name: <input type="text"/>
B5. Date of Injury: <input type="text"/>	

Completing the General Medical Template

PART C: Provider Information	
C1. OWCP Provider ID: <input type="text"/>	C2. Tax ID (SSN/FEIN): <input type="text"/>
C3. Name: <input type="text"/>	C4. Fax Number: <input type="text"/>
C5. Providing care for a family member?: <input type="text"/>	
C6. If Yes, please provide relationship to the claimant: <input type="text"/>	

- C1.** Enter the provider's 9-digit OWCP Provider Identification Number (PIN).
- C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.
- C3.** Enter the Provider's Name.
- C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider's profile, it can be left blank. (Not Required)
- C5.** Confirm if you are providing care for a family member or not.
- C6.** If you are providing care, state your relationship to the claimant. **(Only required if "Yes" was selected in C5)**

Completing the General Medical Template

PART D: Service Line Information

D1. Specific Body Part to be treated:

D2. Is this a second surgery on the same body part?:

D3. Diagnosis Codes: A. B. C. D.

D4. Is this an implant?: D5. Cost of implant:

D6.

From Date	To Date	Diagnosis Pointer				Code Type	Revenue Code	Procedure Code	Modifier	Body Part Modifier	Units/Days Requested
		A	B	C	D						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

D7. Remarks:

- D1.** Enter the specific body part to be treated.
 - D2.** State if this a second surgery to the same body part.
 - D3.** Up to four ICD-9 or ICD-10 codes can be entered.
 - ICD-9 code is applicable if date of service is on/prior to September 30, 2015. Use ICD-10 code if date of service is on/after October 1, 2015.
 - D4.** State if this is an implant.
- Additional information on Part D is continued on the next slide.

Completing the General Medical Template – Cont.

PART D: Service Line Information

D1. Specific Body Part to be treated:

D2. Is this a second surgery on the same body part?:

D3. Diagnosis Codes: A. B. C. D.

D4. Is this an implant?: D5. Cost of implant:

D6.

From Date	To Date	Diagnosis Pointer				Code Type	Revenue Code	Procedure Code	Modifier	Body Part Modifier	Units/Days Requested
		A	B	C	D						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

D7. Remarks:

D5. If this is for an implant, how much does it cost?

D6.

- Enter the DOS range.
- Select the Diagnosis you want to point to from D3, multiple pointers can be selected.
- Select code type (CPT/HCPCS/Revenue Code/NDC Code).
- Enter the code Modifier (if applicable).
- Select a Body Part Modifier option: LT (Left), RT (Right) or 50 (Bilateral). Select 50 if the service is for the back, neck or head area.
- Enter the Units/Days requested.

D7. Enter any additional remarks.

Completing the General Medical Template

Attach any supporting documentation that may help.

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

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Home Health Template



Home Health Template

Requests for Home Health Services that are level a 2 or 3, will require the completion of the Home Health Template.

DFEC Home Health Authorization Request
(Fax # 1-800-215-4901)

Please read the instructions carefully before completing authorization request. Complete all applicable fields. All Prior Authorization requests must either be faxed on this template or be submitted through the Web Bill Processing Portal (<https://owcpmed.dol.gov>). Fax with supporting medical documentation, including the Claimant ID on all pages. Incomplete requests cannot be processed and will be returned.

PART A: Requestor Information

A1. Initial Request Correction
A2. Original Authorization Number (For Correction):
A3. Date Requested:
A4. Requested By: A5. Phone Number:

PART B: Claimant Information

B1. Claimant's Case ID: B2. Date of Birth:
B3. First Name: B4. Last Name:
B5. Date of Injury:

PART C: Provider Information

C1. OWCP Provider ID: C2. Tax ID (SSN/FEIN):
C3. Name: C4. Fax Number:
C5. Providing care for a family member?:
C6. If Yes, please provide relationship to the claimant:

PART D: Service Plan Information

D1. Specific Body Part to be treated:
D2. Diagnosis Codes: A. B. C. D.
D3.

From Date	To Date	Diagnosis Pointer A B C D	Code Type	Procedure Code	Body Part Modifier	Frequency	Duration	Total Units Requested
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

D4. Remarks:

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Completing the Home Health Template

PART A: Requestor Information	
A1. <input type="checkbox"/> Initial Request	<input type="checkbox"/> Correction
A2. Original Authorization Number (For Correction):	<input type="text"/>
A3. Date Requested:	<input type="text"/>
A4. Requested By:	<input type="text"/>
	A5. Phone Number: <input type="text"/>

A1. Select an option:

- Initial Request (new or first time requesting an authorization for home health).
- 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 Home Health Template

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

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

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

B5. Enter the Claimant's Date of Injury (mm/dd/yyyy).

Note: All fields in Part B are required.

PART B: Claimant Information	
B1. Claimant's Case ID: <input type="text"/>	B2. Date of Birth: <input type="text"/>
B3. First Name: <input type="text"/>	B4. Last Name: <input type="text"/>
B5. Date of Injury: <input type="text"/>	

Completing the Home Health Template

PART C: Provider Information	
C1. OWCP Provider ID: <input type="text"/>	C2. Tax ID (SSN/FEIN): <input type="text"/>
C3. Name: <input type="text"/>	C4. Fax Number: <input type="text"/>
C5. Providing care for a family member?: <input type="text"/>	
C6. If Yes, please provide relationship to the claimant: <input type="text"/>	

- C1.** Enter the provider's 9-digit OWCP Provider Identification Number (PIN).
- C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.
- C3.** Enter the Provider's Name.
- C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider's profile, it can be left blank. (Not Required)
- C5.** Confirm if you are providing care for a family member or not.
- C6.** If you are providing care, state your relationship to the claimant. **(Only required if Yes was selected in C5.)**

Completing the Home Health Template

PART D: Service Plan Information

D1. Specific Body Part to be treated:

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

D3.

From Date	To Date	Diagnosis Pointer				Code Type	Procedure Code	Body Part Modifier	Frequency	Duration	Total Units Requested
		A	B	C	D						

D4. Remarks:

D1. Enter the specific body part to be treated.

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

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

Additional information on Part D is continued on the next slide.

Completing the Home Health Template – Cont.

PART D: Service Plan Information

D1. Specific Body Part to be treated:

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

D3.

From Date	To Date	Diagnosis Pointer				Code Type	Procedure Code	Body Part Modifier	Frequency	Duration	Total Units Requested
		A	B	C	D						
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>			
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>			
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>			
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>			
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>			

D4. Remarks:

D3.

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Select Code Type (CPT/HCPCS).
- Enter the procedure code.
- Select a Body Part Modifier Option: LT (Left), RT (Right), or 50 (Bilateral). Select 50 if the service is for the back, neck, or head area.
- Enter the Frequency (How many times a week will the claimant be seen?)
- Enter the Duration (How many total weeks will the claimant be seen?)
- Enter the total units requested (Frequency x Duration = Total Units Requested).

D4. Enter any additional remarks.

Completing the Home Health Template

Any supporting documentation will need to be attached.

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

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

HCPCS J-Code
Unspecified/Unclassified
Template



HCPCS J-Code Unspecified/Unclassified Template

Requests for Unspecified/Unclassified J-Codes (J3490, J3590, J7999, J8499, J8999, and J9999) require the completion of the HCPCS J-Code Unspecified/Unclassified Template.

**DFEC HCPCS J-Code, Unspecified/Unclassified
Authorization Request**
(Fax # 1-800-215-4901)

All Prior Authorization requests for Unspecified/ Unclassified J-Codes (J3490, J3590, J7999, J8499, J8999, and J9999) must be faxed on this form. Fax with supporting documentation including prescription with the Claimant ID on all pages. All fields are required and must be complete. Incomplete requests cannot be processed and will be returned.

PART A: Requestor Information

A1. Initial Request Correction

A2. Original Authorization Number (For Correction): _____

A3. Date Requested: _____

A4. Requested By: _____ A5. Phone Number: _____

PART B: Claimant Information

B1. Claimant's Case ID: _____ B2. Date of Birth: _____

B3. First Name: _____ B4. Last Name: _____

B5. Date of Injury: _____

PART C: Provider Information

C1. OWCP Provider ID: _____ C2. Tax ID (SSN/FEIN): _____

C3. Name: _____ C4. Fax Number: _____

C5. Prescribing Provider Name: _____ C6. Prescribing NPI: _____

PART D: Service Line Information

D1. Specific Body Part to be treated: _____

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

D3.

From Date	To Date	Diagnosis Pointer A B C D	J-Code	NDC	Body Part Modifier	Units Requested
			▼		▼	
			▼		▼	
			▼		▼	
			▼		▼	

D4. Remarks:

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the Instructions for required documents. Please ensure to include Claimant ID on each page.

Completing the HCPCS J-Code Unspecified/Unclassified Template

PART A: Requestor Information	
A1. <input type="checkbox"/> Initial Request	<input type="checkbox"/> Correction
A2. Original Authorization Number (For Correction):	<input type="text"/>
A3. Date Requested:	<input type="text"/>
A4. Requested By:	A5. Phone Number: <input type="text"/>

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 HCPCS J-Code Unspecified/Unclassified Template

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

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

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

B5. Enter the Claimant's Date of Injury (mm/dd/yyyy).

Note: All fields in Part B are required.

PART B: Claimant Information	
B1. Claimant's Case ID: <input type="text"/>	B2. Date of Birth: <input type="text"/>
B3. First Name: <input type="text"/>	B4. Last Name: <input type="text"/>
B5. Date of Injury: <input type="text"/>	

Completing the HCPCS J-Code Unspecified/Unclassified Template

PART C: Provider Information	
C1. OWCP Provider ID: <input type="text"/>	C2. Tax ID (SSN/FEIN): <input type="text"/>
C3. Name: <input type="text"/>	C4. Fax Number: <input type="text"/>
C5. Prescribing Provider Name: <input type="text"/>	C6. Prescribing NPI: <input type="text"/>

- C1.** Enter the provider's 9-digit OWCP Provider Identification Number (PIN).
- C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.
- C3.** Enter the Provider's Name.
- C4.** Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the provider's profile, it can be left blank. **(Not Required)**
- C5.** Enter the doctor's name that prescribed the medication.
- C6.** Enter the doctor's NPI that prescribed the medication.

Completing the HCPCS J-Code Unspecified/Unclassified Template

D1. Enter the specific body part to be treated.

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

- ICD-9 code is applicable if date of service is on/prior to 09/30/2015. Use ICD-10 code if date of service is on/after 10/01/2015.

D3.

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Enter the Unspecified/Unclassified J-Code.
- Enter the National Drug Code (NDC) number.
- Select a Body Part Modifier option: LT (Left), RT (Right) or 50 (Bilateral). Select 50 if the equipment is for the back, neck or head area.
- Enter the number of Units requested.

D4. Enter any additional remarks.

PART D: Service Line Information						
D1. Specific Body Part to be treated: <input type="text"/>						
D2. Diagnosis Codes: A. <input type="text"/> B. <input type="text"/> C. <input type="text"/> D. <input type="text"/>						
D3.						
From Date	To Date	Diagnosis Pointer A B C D	J-Code	NDC	Body Part Modifier	Units Requested
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D4. Remarks: <input type="text"/>						

Completing the HCPCS J-Code Unspecified/Unclassified Template

A J-code prescription from the prescribing doctor is required.

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

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Surgical Package Template



Surgical Package Template

Requests for Surgical procedures that are level 2 or 3 services, will require the completion of a Surgical Package Authorization Template.

DFEC Surgical Package Authorization Request
(Fax # 1-800-215-4901)

(All Prior Authorization requests must be faxed on this template or submitted via the CBP Bill Processing Portal (enter CNSI site). Fax with supporting documentation, including the Claimant ID on all pages. All fields marked as required must be completed/checked. If the surgery will be rendered at an inpatient (more than 24 hours) or Outpatient/Ambulatory Surgery Center (ASC) facility (less than 24 hours), all fields of Professionals at Surgery must be checked. If the surgery will be rendered in an Office (less than 8 hours), check only the Physician/Surgeon, Physician's Assistant, and/or CRNA. (Note: All parties must already be enrolled in DFEC Program).

PART A: Requestor Information

A1. Initial Request Correction
A2. Original Authorization Number (For Correction):
A3. Date Requested:
A4. Requested By: A5. Phone Number:

PART B: Claimant Information

B1. Claimant's Case ID: B2. Date of Birth:
B3. First Name: B4. Last Name:
B5. Date of Injury:

PART C: Provider Information

C1. Are you the Primary Surgeon?:
C2. OWCP Provider ID: C3. Tax ID (SSN/FEIN):
C4. Name: C5. Fax Number:

PART D: Surgery Information

D1. Date of Surgery:
D2. INPATIENT SURGERY (More than 24 hours) – Include all Proposed Professionals in the Operating Room.
 OUTPATIENT (Less than 24 hours) – Include all Proposed Professionals in the Operating Room.
 ASC SURGERY – Include all Proposed Professionals in the Operating Room.
 OFFICE SURGERY (Less than 8 hours) – Include all Proposed Professional present during surgical procedure.
D3. Check the location/professional requiring authorization for this surgery, to include the Surgeon submitting this form.

SELECT PROFESSIONAL	PROFESSIONAL AT SURGERY
<input type="checkbox"/>	Facility
<input type="checkbox"/>	Surgeon
<input type="checkbox"/>	Asst Surgeon
<input type="checkbox"/>	Anesthesiologist
<input type="checkbox"/>	CRNA
<input type="checkbox"/>	Physicians Asst

PART E: Service Line Information

E1. Specific Body Part to be treated:
E2. Diagnosis Codes: A. B. C. D.
E3. Has this surgery been performed previously on the same anatomical site?:
E4. Will this claimant require Home Health Services after surgery?:
E5. Will this claimant require Physical/Occupational Therapy Services after surgery?:
E6.

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

E7. Remarks:

Note: To request Prior Authorization for Home Health Services or Physical Therapy Services after Surgery, these professionals must use the [Home Health Services or Physical Therapy/Occupational Therapy Authorization Request Form](#).

PART F: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Completing the Surgical Package Template

PART A: Requestor Information	
A1. <input type="checkbox"/> Initial Request	<input type="checkbox"/> Correction
A2. Original Authorization Number (For Correction):	<input type="text"/>
A3. Date Requested:	<input type="text"/>
A4. Requested By:	A5. Phone Number: <input type="text"/>

A1. Select an option:

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

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

A3. Type the date the authorization is being completed.

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

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

Completing the Surgical Package Template

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

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

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

B5. Enter the Claimant's Date of Injury (mm/dd/yyyy).

Note: All fields in Part B are required.

PART B: Claimant Information	
B1. Claimant's Case ID: <input type="text"/>	B2. Date of Birth: <input type="text"/>
B3. First Name: <input type="text"/>	B4. Last Name: <input type="text"/>
B5. Date of Injury: <input type="text"/>	

Completing the Surgical Package Template

PART C: Provider Information	
C1. Are you the Primary Surgeon?: <input type="text"/>	
C2. OWCP Provider ID: <input type="text"/>	C3. Tax ID (SSN/FEIN): <input type="text"/>
C4. Name: <input type="text"/>	C5. Fax Number: <input type="text"/>

- C1.** Select the appropriate option (YES or NO), if the primary surgeon is completing this form.
- C2.** Enter the rendering provider's OWCP ID.
- C3.** Enter the provider's Tax ID (Social Security Number or Federal Employer Identification Number).
- C4.** Enter the provider's name.
- C5.** 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 Surgical Package Template

D1. Enter the date of the surgery.

D2. Select the site where the surgery will take place.

- Inpatient
- Outpatient
- Ambulatory Surgery Center (ASC)
- Office

D3. Select all that will require an authorization and include the surgeon requesting the authorization.

- Facility
- Surgeon
- Assistant Surgeon (AS)
- Anesthesiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Physicians Assistant (PA)

Note: One authorization will cover all selected.

PART D: Surgery Information

D1. Date of Surgery:

- D2. INPATIENT SURGERY (More than 24 hours) – Include all Proposed Professionals in the Operating Room.
- OUTPATIENT (Less than 24 hours) – Include all Proposed Professionals in the Operating Room.
- ASC SURGERY – Include all Proposed Professionals in the Operating Room.
- OFFICE SURGERY (Less than 8 hours) – Include all Proposed Professional present during surgical procedure.

D3. Check the location/professional requiring authorization for this surgery, to include the Surgeon submitting this form.

SELECT PROFESSIONAL	PROFESSIONAL AT SURGERY
<input type="checkbox"/>	Facility
<input type="checkbox"/>	Surgeon
<input type="checkbox"/>	Asst Surgeon
<input type="checkbox"/>	Anesthesiologist
<input type="checkbox"/>	CRNA
<input type="checkbox"/>	Physicians Asst

Completing the Surgical Package Template

PART E: Service Line Information

E1. Specific Body Part to be treated:

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

E3. Has this surgery been performed previously on the same anatomical site?:

E4. Will this claimant require Home Health Services after surgery?:

E5. Will this claimant require Physical/Occupational Therapy Services after surgery?:

E6.

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

E7. Remarks:

E1. Enter the specific body part to be treated.

E2. Up to four ICD-9 or ICD-10 codes can be entered.

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

E3. Has there been a previous surgery on the body part you are treating?

E4. Will Home Health be required after the surgery?

E5. Will Physical/Occupational Therapy be required after the surgery?

Additional information on Part E is continued on the next slide.

Completing the Surgical Package Template – Cont.

PART E: Service Line Information

E1. Specific Body Part to be treated:

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

E3. Has this surgery been performed previously on the same anatomical site?:

E4. Will this claimant require Home Health Services after surgery?:

E5. Will this claimant require Physical/Occupational Therapy Services after surgery?:

E6.

From Date	To Date	Diagnosis Pointer				Code Type	Procedure Code	Modifier	Body Part Modifier	Units/Days Requested
		A	B	C	D					
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			<input type="text"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			<input type="text"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			<input type="text"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			<input type="text"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			<input type="text"/>	

E7. Remarks:

E6.

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Select the Code Type (CPT/HCPCS).
- Enter the Procedure Code.
- Enter the procedure Modifier (if applicable).
- Select a Body Part Modifier option: LT(Left), RT(Right) or 50(Bilateral). Select 50 if the equipment is for the back, neck or head area.
- Enter the number of Units/Days requested.

E7. Enter any additional remarks.

Completing the Surgical Package Template

PART F: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Attach any supporting documentation needed.

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

Travel Template



Travel Template

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

- **A0100** - Taxi
- **A0110** - Bus, intra/interstate carrier
- **A0120** - Mini-Bus, mountain area transports, and other transports
- **A0130** - Wheelchair Van
- **A0140** – Air Travel
- **A0170** - Transport Parking Fees/Tolls

DFEC Travel Authorization Request
(Fax # 1-800-215-4901)

Please read the instructions carefully before completing authorization request. Complete all applicable fields. All Prior Authorization requests must either be faxed on this template or be submitted through the Web Bill Processing Portal (<https://owcpmed.dol.gov>). Fax with supporting medical documentation, including the Claimant ID on all pages. Incomplete requests cannot be processed and will be returned.

PART A: Requestor Information

A1. Initial Request Correction

A2. Original Authorization Number (For Correction): _____

A3. Date Requested: _____

A4. Requested By: _____ A5. Phone Number: _____

PART B: Claimant Information

B1. Claimant's Case ID: _____ B2. Date of Birth: _____

B3. First Name: _____ B4. Last Name: _____

B5. Date of Injury: _____

PART C: Provider Information

C1. OWCP Provider ID: _____ C2. Tax ID (SSN/FEIN): _____

C3. Name: _____ C4. Fax Number: _____

C5. Providing care for a family member?: Yes No

C6. If Yes, please provide relationship to the claimant: _____

PART D: Travel Information

D1. Travel From: _____ D2. Travel To: _____

D3.

From Date	To Date	Travel Code	Estimated Total Charge	Estimated Miles

D4. Remarks: _____

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Completing the Travel Template

PART A: Requestor Information	
A1. <input type="checkbox"/> Initial Request	<input type="checkbox"/> Correction
A2. Original Authorization Number (For Correction):	<input type="text"/>
A3. Date Requested:	<input type="text"/>
A4. Requested By:	A5. Phone Number: <input type="text"/>

A1. Select an option:

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

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

A3. Type the date the authorization is being completed.

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

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

Completing the Travel Template

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

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

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

B5. Enter the Claimant's Date of Injury (mm/dd/yyyy).

Note: All fields in Part B are required.

PART B: Claimant Information	
B1. Claimant's Case ID: <input type="text"/>	B2. Date of Birth: <input type="text"/>
B3. First Name: <input type="text"/>	B4. Last Name: <input type="text"/>
B5. Date of Injury: <input type="text"/>	

Completing the Travel Template

PART C: Provider Information	
C1. OWCP Provider ID: <input type="text"/>	C2. Tax ID (SSN/FEIN): <input type="text"/>
C3. Name: <input type="text"/>	C4. Fax Number: <input type="text"/>
C5. Providing care for a family member?: <input type="text"/>	
C6. If Yes, please provide relationship to the claimant: <input type="text"/>	

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

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

C3. Enter the Provider's Name.

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

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

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

Completing the Travel Template

D1. Select the location where the travel started from.

D2. Select the location where the travel ended.

D3.

- Enter the travel from and to date.
- Enter the travel code(s).
- Enter the estimated total charge of the travel.
- Enter the estimated miles traveled (**For claimant travel reimbursement only**).

D4. Enter any additional remarks.

PART D: Travel Information				
D1. Travel From:		<input type="text"/>	D2. Travel To: <input type="text"/>	
D3.				
From Date	To Date	Travel Code	Estimated Total Charge	Estimated Miles
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D4. Remarks: <input type="text"/>				

Completing the Travel Template

Attach Receipts or Invoices to confirm the estimated total charge.

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

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Physical
Therapy/Occupational
Therapy Template



Physical Therapy/Occupational Therapy Template

Requests for Physical Therapy (PT) & Occupational Therapy (OT) services that are level 2 or 3 will require the completion of a Physical Therapy/Occupational Therapy Template.

DFEC Physical Therapy/Occupational Therapy Authorization Request
(Fax # 1-800-215-4901)

Please read the instructions carefully before completing authorization request. Complete all applicable fields. All Prior Authorization requests must either be faxed on this template or be submitted through the Web Bill Processing Portal (<https://owcpmed.dol.gov>). Fax with supporting medical documentation, including the Claimant ID on all pages. Incomplete requests cannot be processed and will be returned.

PART A: Requestor Information

A1. Initial Request Correction
 A2. Original Authorization Number (For Correction): _____
 A3. Date Requested: _____
 A4. Requested By: _____ A5. Phone Number: _____

PART B: Claimant Information

B1. Claimant's Case ID: _____ B2. Date of Birth: _____
 B3. First Name: _____ B4. Last Name: _____
 B5. Date of Injury: _____

PART C: Provider Information

C1. OWCP Provider ID: _____ C2. Tax ID (SSN/FEIN): _____
 C3. Name: _____ C4. Fax Number: _____
 C5. Providing care for a family member?:
 C6. If Yes, please provide relationship to the claimant: _____

PART D: Therapy Plan Information

D1. Specific Body Part to be treated: _____
 D2. Diagnosis Codes: A. _____ B. _____ C. _____ D. _____
 D3. Is the requested therapy related to post-operative treatment within 60 days after surgery?
 D4.

From Date	To Date	Diagnosis Pointer				Code Type	Procedure Code	Modifier	Body Part Modifier	# of units per procedural visit	Frequency	Duration	Total units requested
		A	B	C	D								

D5. Remarks: _____

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Completing the Physical Therapy/Occupational Therapy Template

PART A: Requestor Information

A1. Initial Request Correction

A2. Original Authorization Number (For Correction):

A3. Date Requested:

A4. Requested By: A5. Phone Number:

A1. Select an option:

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

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

A3. Type the date the authorization is being completed.

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

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

Completing the Physical Therapy/Occupational Therapy Template

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

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

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

B5. Enter the Claimant's Date of Injury (mm/dd/yyyy).

Note: All fields in Part B are required.

PART B: Claimant Information	
B1. Claimant's Case ID: <input type="text"/>	B2. Date of Birth: <input type="text"/>
B3. First Name: <input type="text"/>	B4. Last Name: <input type="text"/>
B5. Date of Injury: <input type="text"/>	

Completing the Physical Therapy/Occupational Therapy Template

PART C: Provider Information	
C1. OWCP Provider ID: <input type="text"/>	C2. Tax ID (SSN/FEIN): <input type="text"/>
C3. Name: <input type="text"/>	C4. Fax Number: <input type="text"/>
C5. Providing care for a family member?: <input type="text"/>	
C6. If Yes, please provide relationship to the claimant: <input type="text"/>	

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

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

C3. Enter the Provider's Name.

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

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

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

Completing the Physical Therapy/Occupational Therapy Template

D1. Enter the specific body part to be treated.

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

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

D3. Is the therapy related to treatment within 60 days after surgery?

Additional information on Part D is continued on the next slide.

PART D: Therapy Plan Information

D1. Specific Body Part to be treated: _____

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

D3. Is the requested therapy related to post-operative treatment within 60 days after surgery?

D4.

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

D5. Remarks: _____

Completing the Physical Therapy/Occupational Therapy Template – Cont.

D4.

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Select if the Code Type is a HCPCS or CPT.
- Enter a Modifier (if applicable).
- Select a Body Part Modifier option: LT (Left), RT (Right) or 50 (Bilateral). Select 50 if the equipment is for the back, neck or head area.
- Enter the number of units per procedure (1 unit = 15 mins).
- Enter the frequency (How many times a week will the claimant be seen?)
- Enter the duration (How many total weeks will the claimant be seen?)
- Enter the total units requested (# of Units Per Procedure x Frequency x Duration = Total Units Requested).

D5. Enter any additional remarks.

PART D: Therapy Plan Information

D1. Specific Body Part to be treated: _____

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

D3. Is the requested therapy related to post-operative treatment within 60 days after surgery?

D4.

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

D5. Remarks: _____

Completing the Physical Therapy/Occupational Therapy Template

*A prescription from the prescribing doctor with (MD, PHD, DO or DPM) credentials is required along with the treatment plan.

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

PART E: Supporting Documents

All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

Authorization Submission Methods



Authorization Submission Methods

Authorization Templates can be submitted via:

- **Direct Data Entry (DDE)** in the Workers' Compensation Medical Bill Processing (WCMBP) System.
- **Fax** at 800.215.4901.
- **Mail** to P.O. Box 8300 London, KY 40742-8300.

Authorizations are processed within 2 business days of receipt. To check on your Authorization status, visit the Office of Workers' Compensation Programs, Medical Bill Processing Portal at <https://owcpmed.dol.gov> or you may speak with a customer service representative at 844-493-1966.



THANK YOU!

