# DFEC Authorization Templates

# Introduction

- Overview
- How to complete the DFEC Authorization Templates:
  - Durable Medical Equipment (DME)
  - General Medical
  - Home Health
  - Unspecified/Unclassified J-Codes
  - Surgical Package
  - Travel
  - Physical Therapy/Occupational Therapy
- Authorization Submission Methods

# Overview

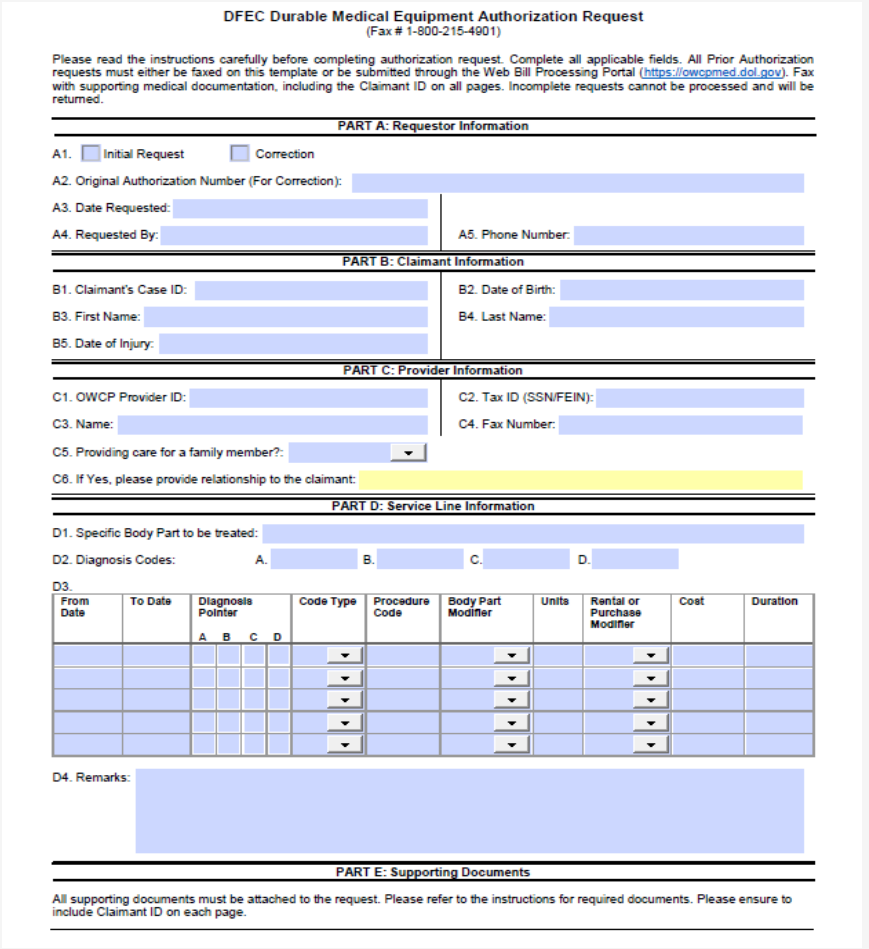
When claimants are treated for their work-related injuries, or occupational diseases, or both, providers are required to secure an approved prior authorization for certain services. DFEC provides the prior authorization request templates for Provider use when requesting prior authorization. These templates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

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

# Durable Medical Equipment (DME) 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 A B C D | Code Type | Procedure Code | Body Part Modifier | Units | Rental or Purchase Modifier | Cost | Duration |
|---|---|---|---|---|---|---|---|---|---|
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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 (1)

**A1.** Select an option:

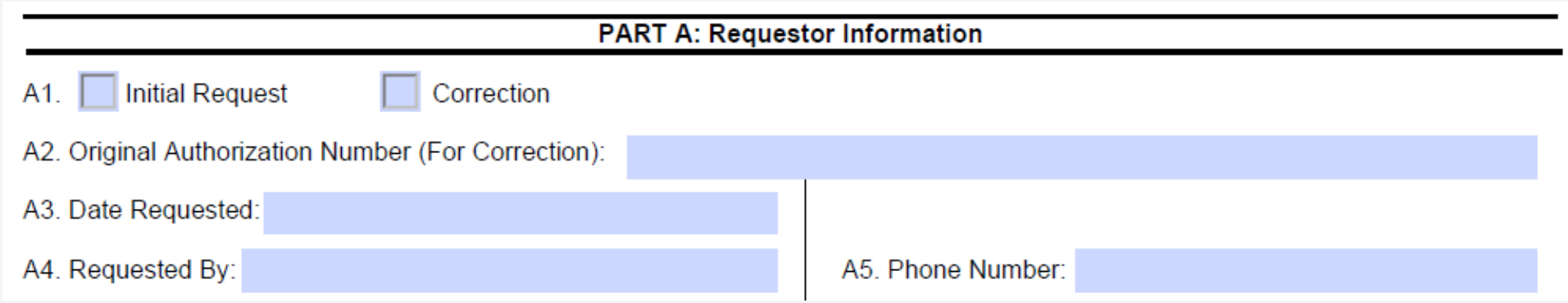
- Initial Request (new or first time requesting an authorization for the DME).
- Correction (to update or correct an authorization that is currently on file).

**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 (2)

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

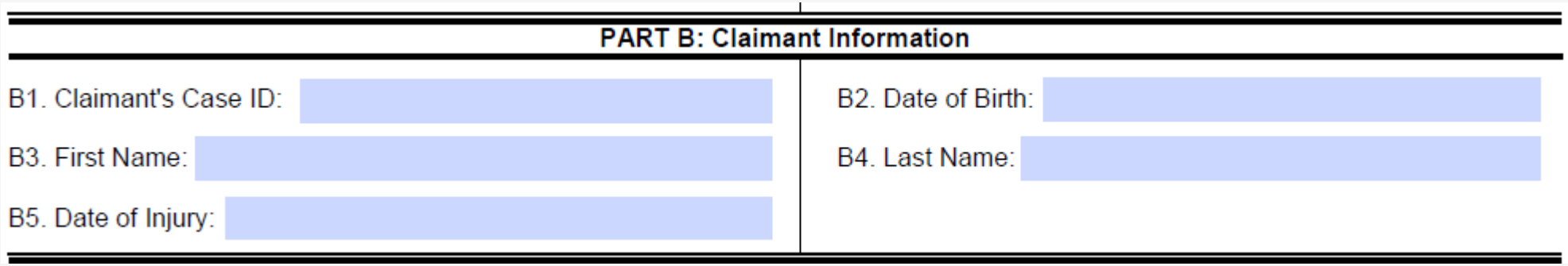
**B2.** Enter the Claimant's Date of Birth (mm/dd/yyyy).

**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: | B2. Date of Birth: |
| B3. First Name: | B4. Last Name: |
| B5. Date of Injury: | |

# Completing the Durable Medical Equipment Template (3)

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

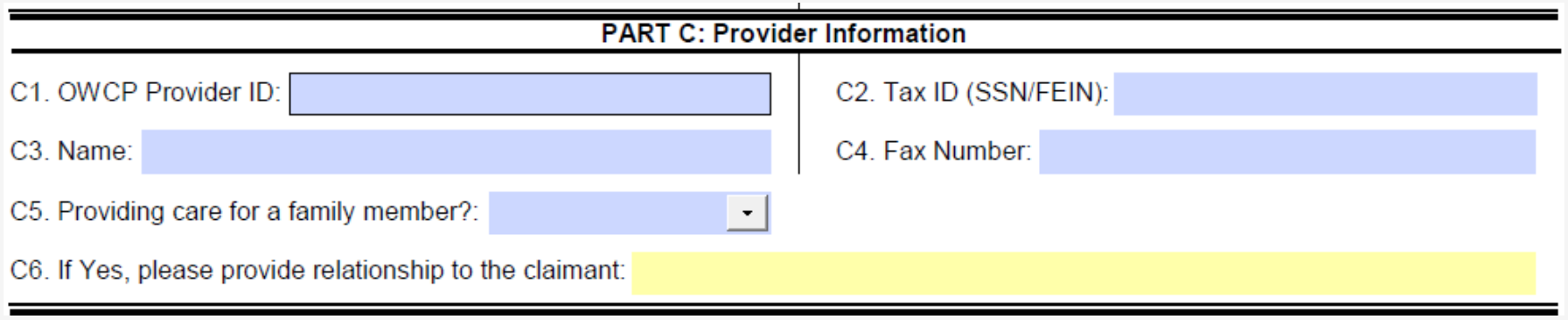
**C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.

**C3.** Enter the Provider's Name.

**C4.** Enter a fax number where you can receive communication regarding authorization requests. 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 Durable Medical Equipment Template (4)

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

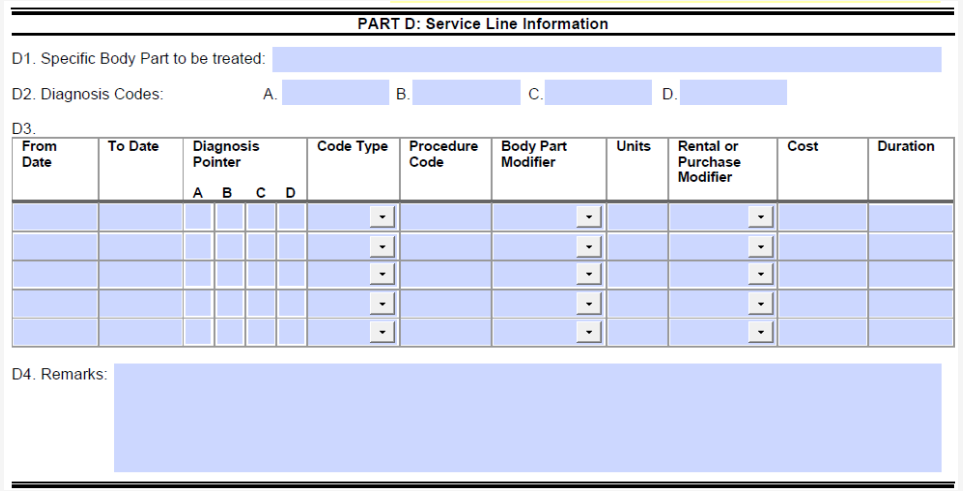
**D2.** Up to four ICD-9 or ICD-10 codes can be entered.

- ICD-9 code is applicable if date of service is on 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 appropriate Diagnosis from the Diagnosis Pointer field in 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).
- 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)


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 | Code Type | Procedure Code | Body Part Modifier | Units | Rental or Purchase Modifier | Cost | Duration |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
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D4. Remarks:

# Completing the Durable Medical Equipment Template (5)

A prescription and treatment plan from the prescribing doctor are required documents

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

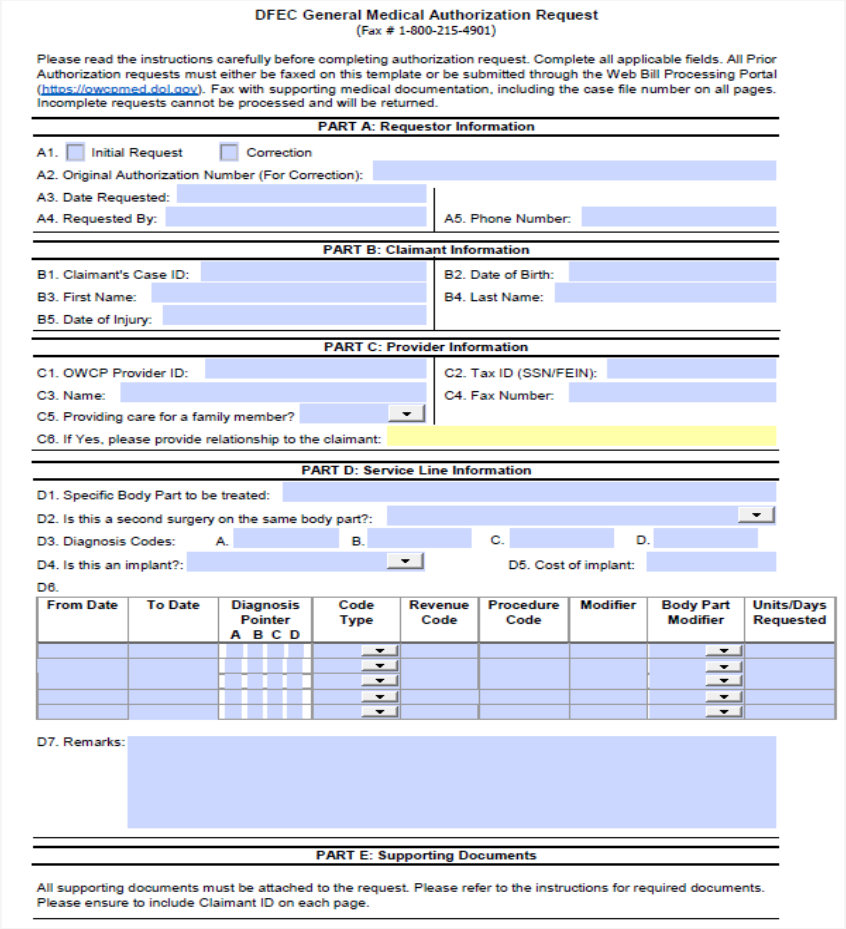
**PART E: Supporting Documents**

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.

# General Medical Template

# General Medical Template (1)

Requests for General Medical Services that are a level 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://owcpmed.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?
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?:
D3. Diagnosis Codes: A. B. C. D.
D4. Is this an implant?:
D5. Cost of implant:
D6.

| From Date | To Date | Diagnosis Pointer A B C D | Code Type | Revenue Code | Procedure Code | Modifier | Body Part Modifier | Units/Days Requested |
|---|---|---|---|---|---|---|---|---|
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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 (1)

**A1.** Select an option:

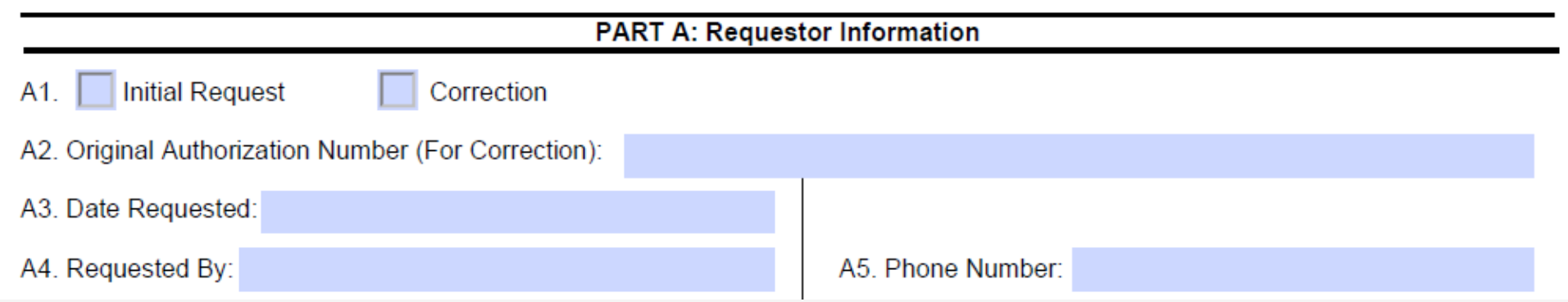
- Initial Request (new or first time requesting an authorization for general medical).
- Correction (to update or correct an authorization that is currently on file).

**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 (2)

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

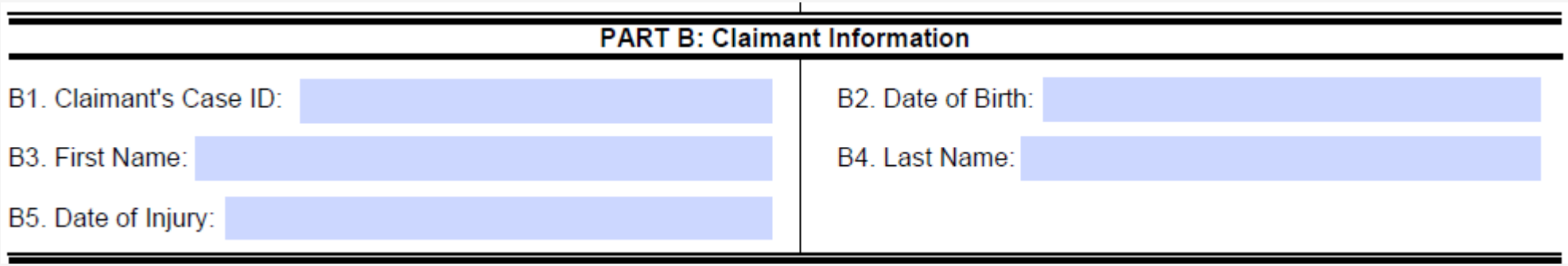
**B2.** Enter the Claimant's Date of Birth (mm/dd/yyyy).

**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.



# Completing the General Medical Template (3)

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

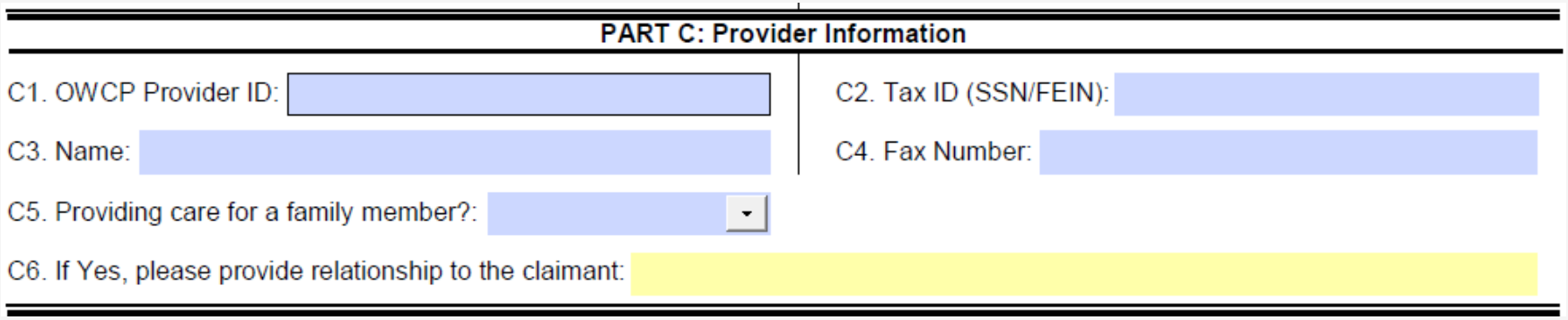
**C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.

**C3.** Enter the Provider's Name.

**C4.** Enter a fax number where you can receive communication regarding authorization requests. 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 (4)

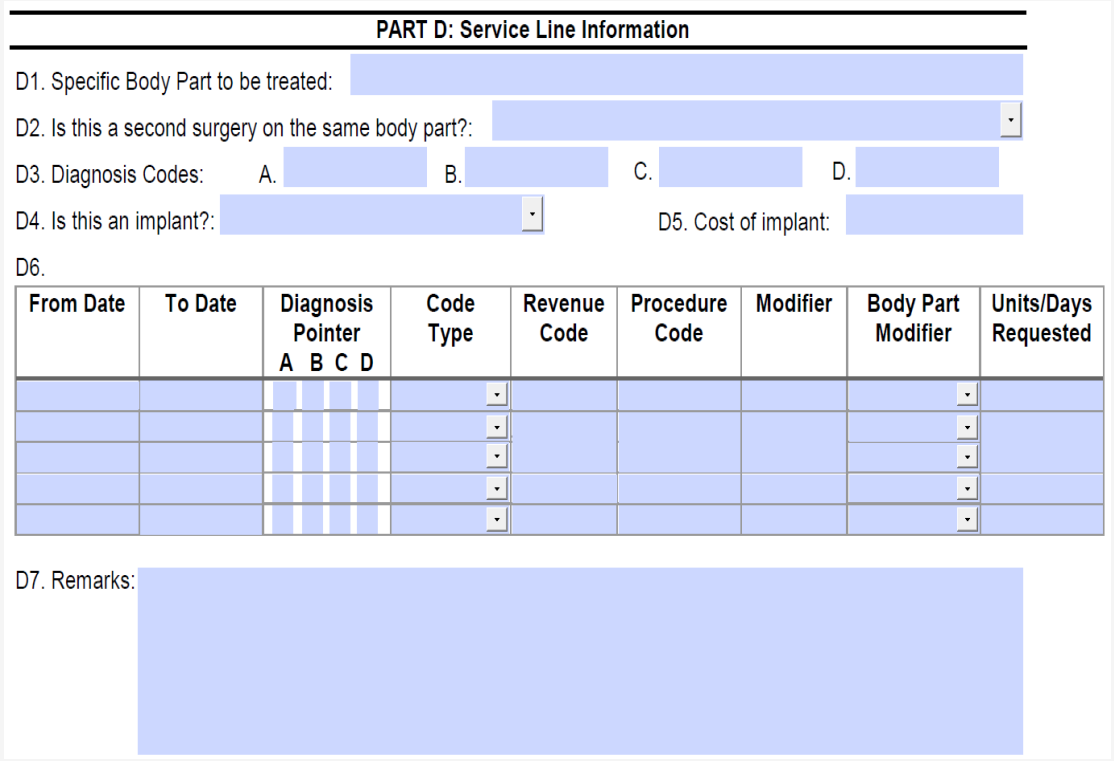
**D1.** Enter the specific body part to be treated.

**D2.** State if this is 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 or prior to September 30, 2015. Use ICD-10 code if date of service is on or after October 1, 2015.

**D4.** State if this is an implant.

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



**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 A B C D | Code Type | Revenue Code | Procedure Code | Modifier | Body Part Modifier | Units/Days Requested |
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D7. Remarks:

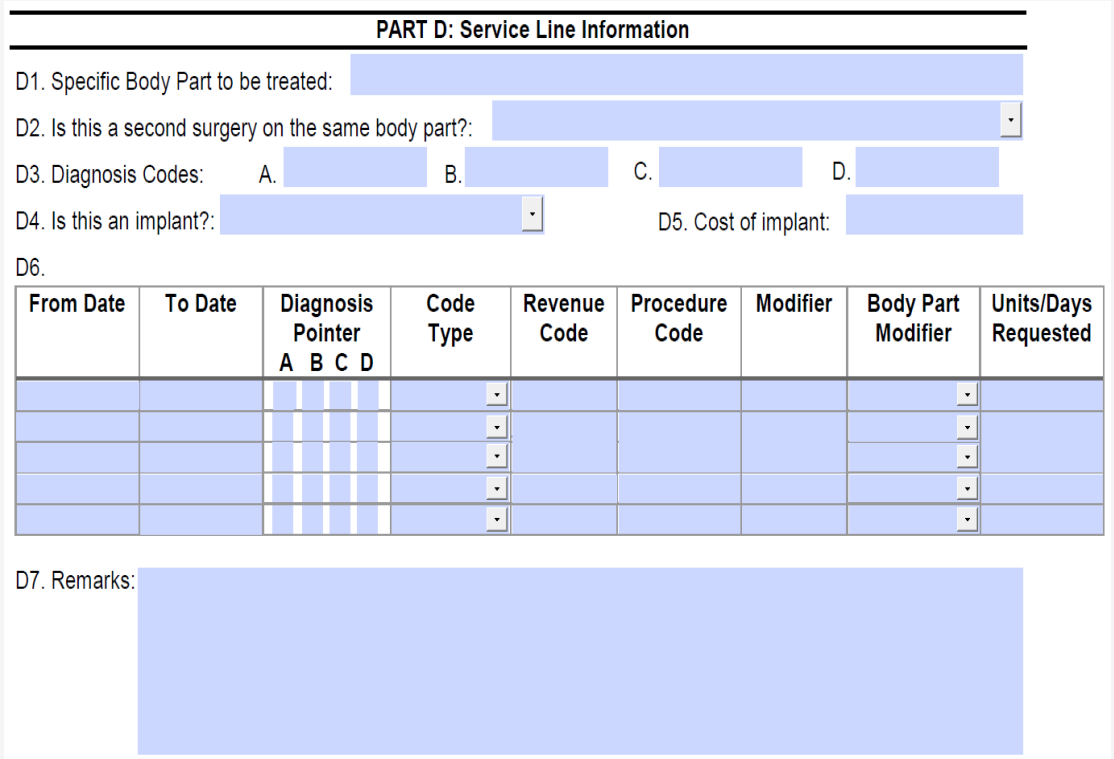
# Completing the General Medical Template (5)

**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).
- Enter the Units/Days Requested.

**D7.** Enter any additional remarks.



**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 A B C D | Code Type | Revenue Code | Procedure Code | Modifier | Body Part Modifier | Units/Days Requested |
|---|---|---|---|---|---|---|---|---|
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D7. Remarks:

# Completing the General Medical Template (6)

Attach any supporting documentation that may help.

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

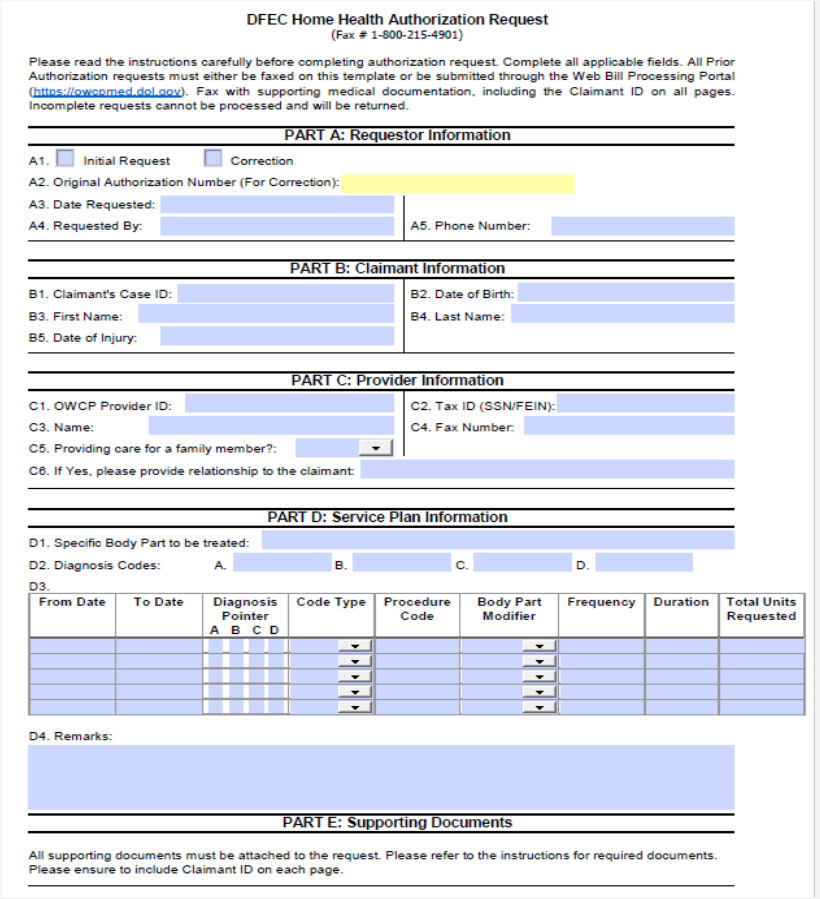
**PART E: Supporting Documents**

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 (1)

Requests for Home Health Services that are a level 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 |
|---|---|---|---|---|---|---|---|---|
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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 (1)

**A1.** Select an option:

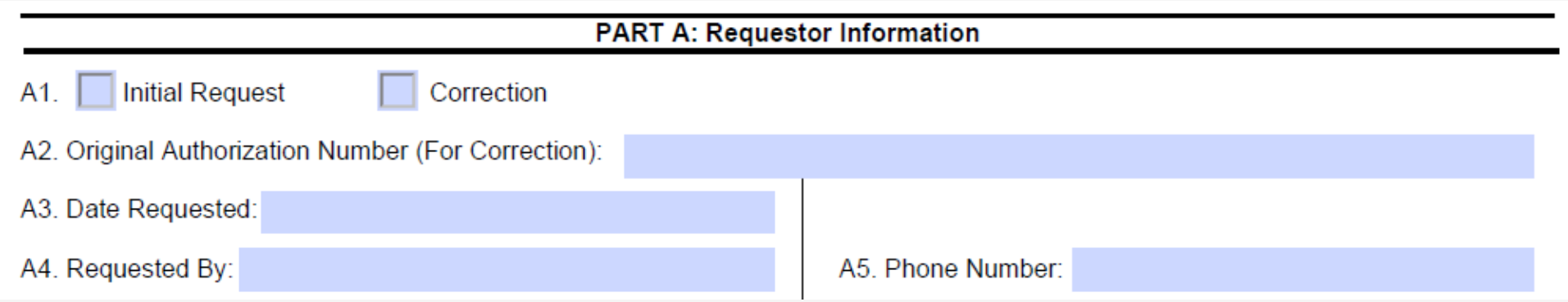
- Initial Request (new or first time requesting an authorization for home health).
- Correction (to update or correct an authorization that is currently on file).

**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 (2)

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

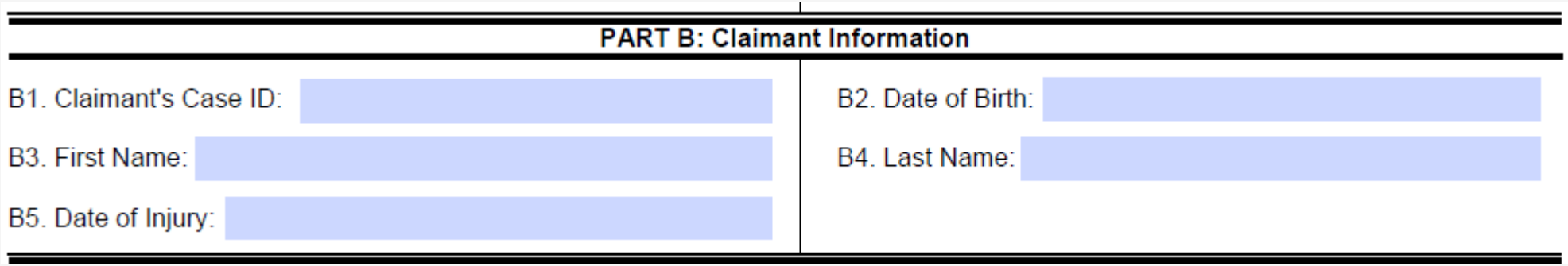
**B2.** Enter the Claimant's Date of Birth (mm/dd/yyyy).

**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.



# Completing the Home Health Template (3)

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

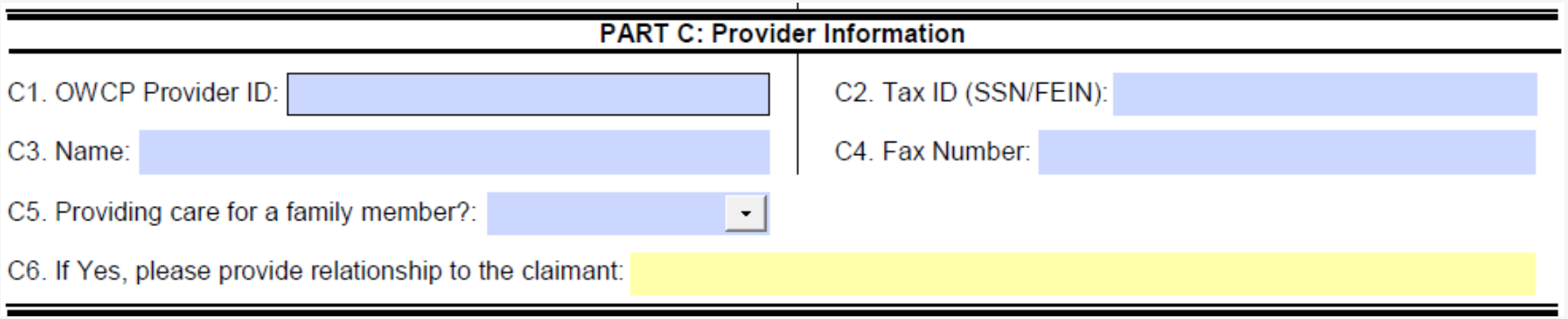
**C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.

**C3.** Enter the Provider's Name.

**C4.** Enter a fax number where you can receive communication regarding authorization requests. 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.)



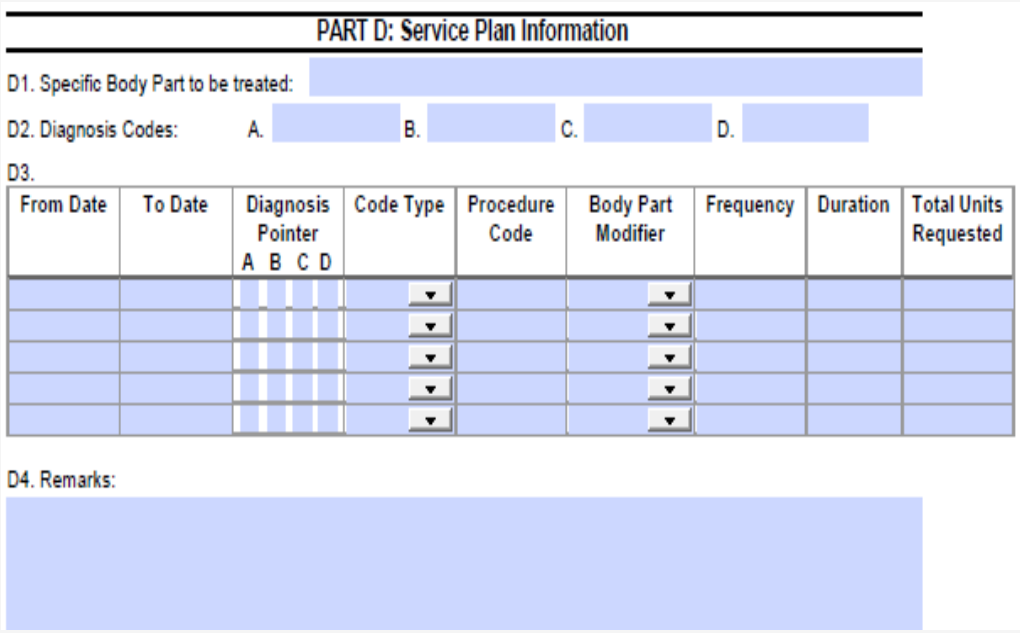
# Completing the Home Health Template (4)

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

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



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 |
|---|---|---|---|---|---|---|---|---|
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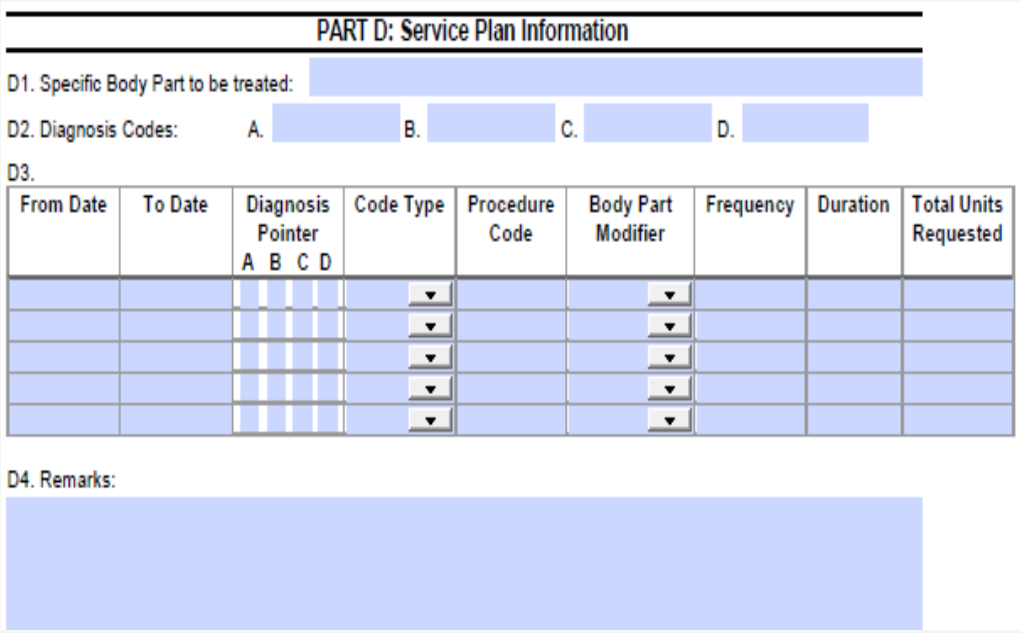
D4. Remarks:

# Completing the Home Health Template (5)

**D3.**

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2, multiple pointers can be selected.
- Select Code Type (CPT or HCPCS).
- Enter the procedure code.
- Select a Body Part Modifier Option: LT (Left), RT (Right), or 50 (Bilateral).
- 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.


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 |
|---|---|---|---|---|---|---|---|---|
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D4. Remarks:

# Completing the Home Health Template (6)

Any supporting documentation will need to be attached.

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

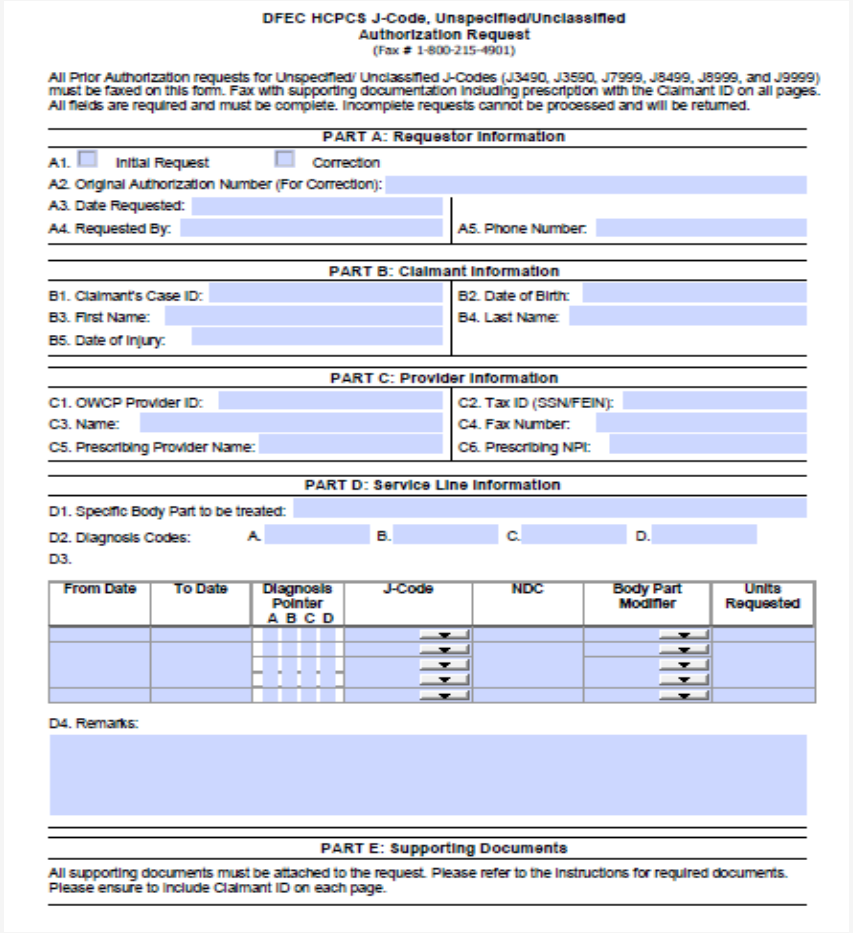
**PART E: Supporting Documents**

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 (1)

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 |
|---|---|---|---|---|---|---|
| | | | | | | |
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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 (1)

**A1.** Select an option:

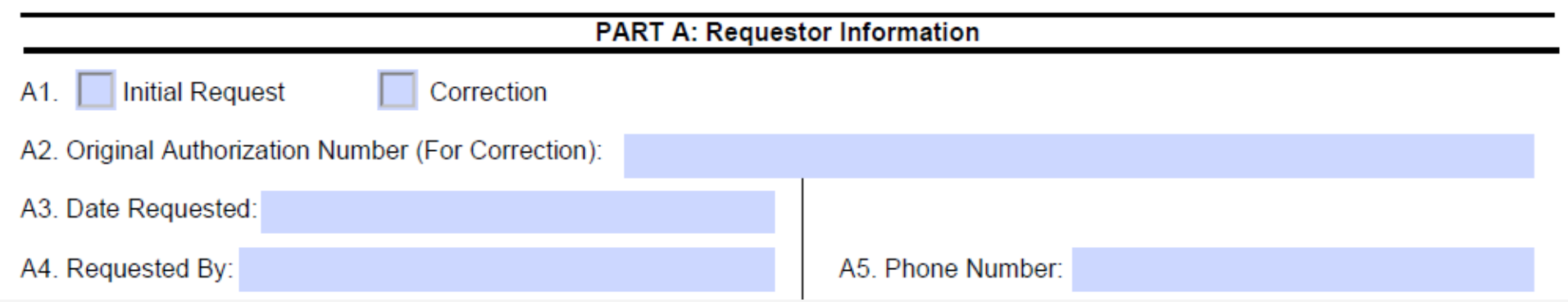
- Initial Request (new or first time requesting an authorization).
- Correction (to update or correct an authorization that is currently on file).

**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 (2)

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

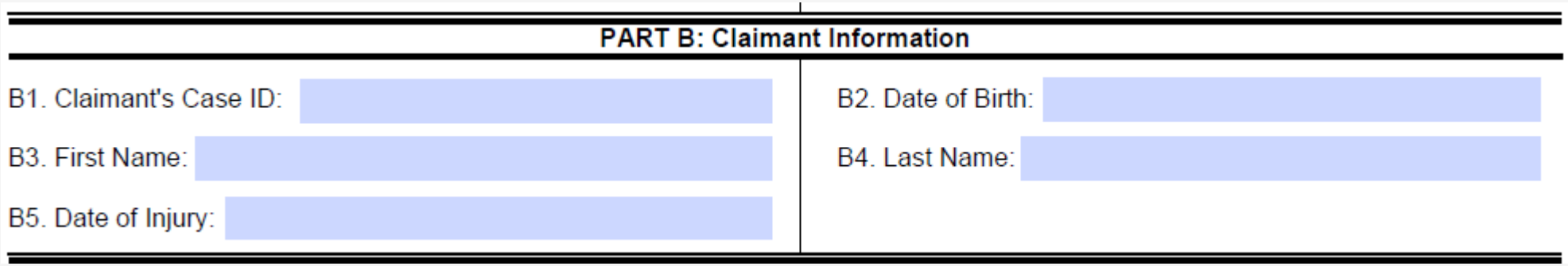
**B2.** Enter the Claimant's Date of Birth (mm/dd/yyyy).

**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: | B2. Date of Birth: |
| B3. First Name: | B4. Last Name: |
| B5. Date of Injury: | |

# Completing the HCPCS J-Code Unspecified/Unclassified Template (3)

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

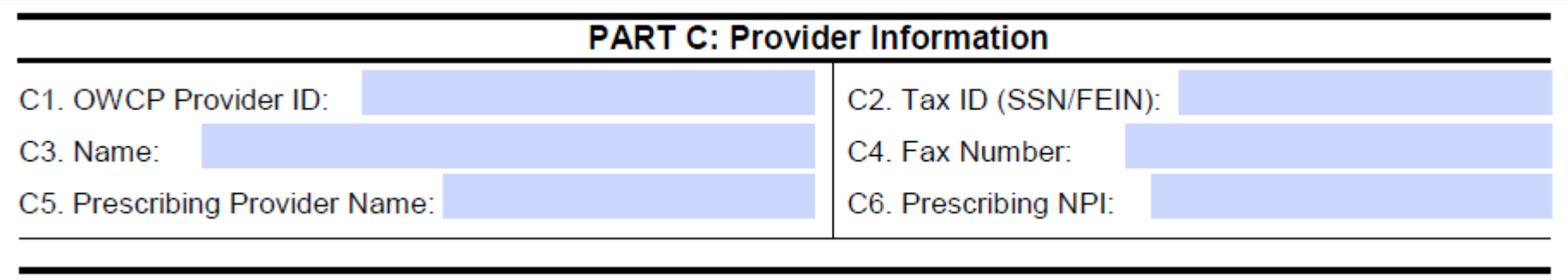
**C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID entered in C1.

**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.



| 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: |

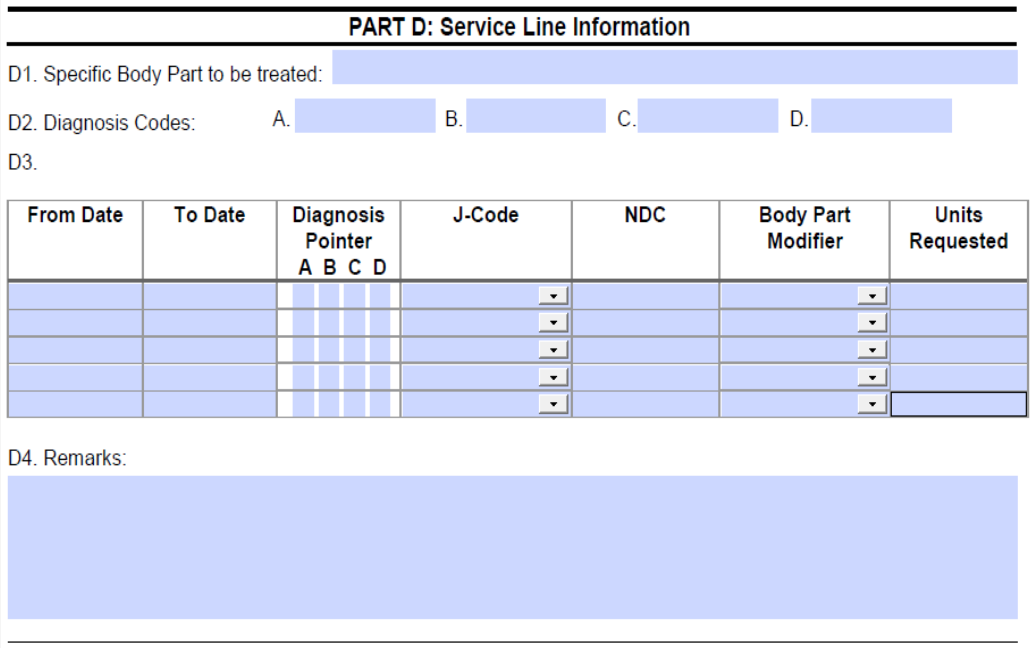
# Completing the HCPCS J-Code Unspecified/Unclassified Template (4)

**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 or prior to 09/30/2015. Use ICD-10 code if date of service is on or 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).
- Enter the number of Units requested.

**D4.** Enter any additional remarks.


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:

# Completing the HCPCS J-Code Unspecified/Unclassified Template (5)

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

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

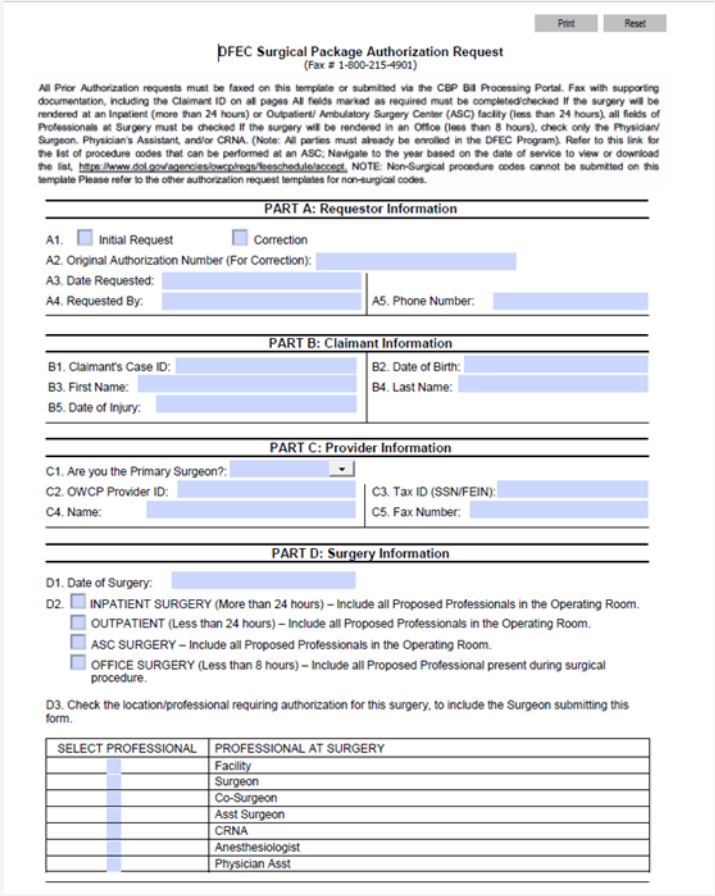
**PART E: Supporting Documents**

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 (1)

Requests for surgical procedures for level 2 or 3 services require a completed Surgical Package Authorization Request template.



Print Reset

**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. 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 the DFEC Program). Refer to this link for the list of procedure codes that can be performed at an ASC; Navigate to the year based on the date of service to view or download the list, https://www.dol.gov/agencies/owcp/regs/feeschedule/accept. NOTE: Non-Surgical procedure codes cannot be submitted on this template Please refer to the other authorization request templates for non-surgical codes.

**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 |
|---|---|
| | Facility |
| | Surgeon |
| | Co-Surgeon |
| | Asst Surgeon |
| | CRNA |
| | Anesthesiologist |
| | Physician 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 |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

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 (1)

**A1.** Select an option:

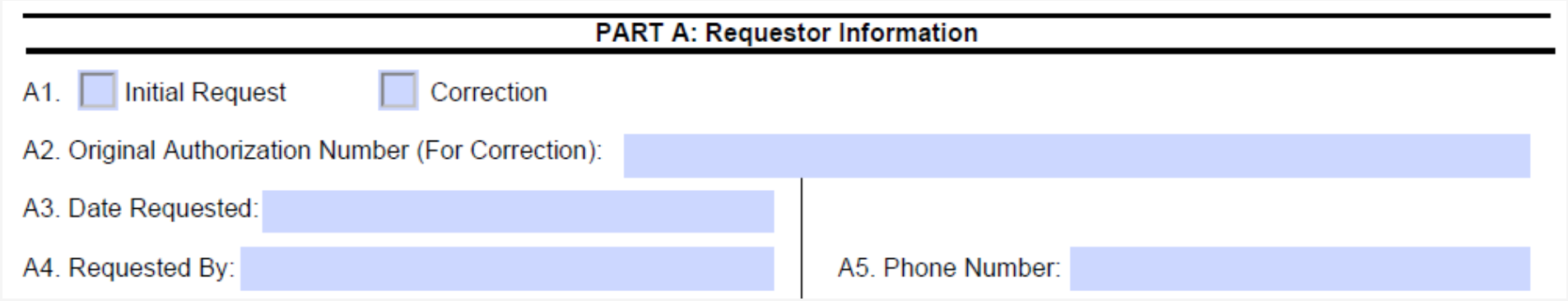
- Initial Request (new or first time requesting an authorization for a surgical procedure).
- Correction (to update or correct an authorization that is currently on file).

**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 (2)

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

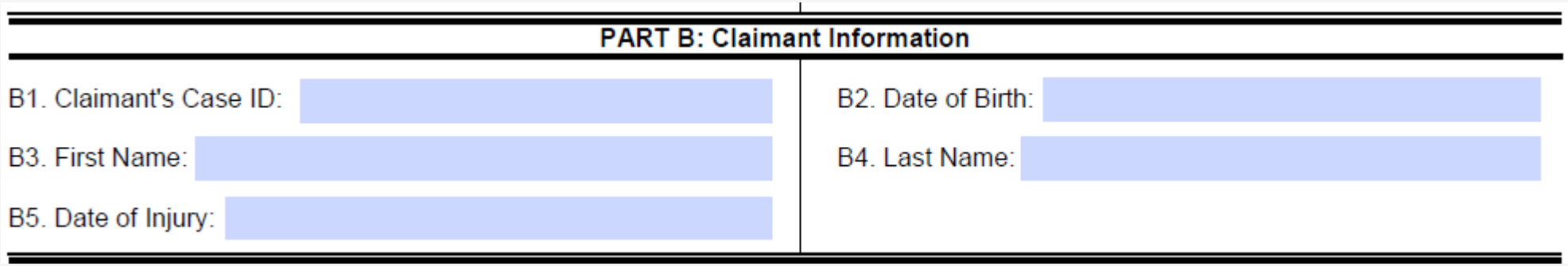
**B2.** Enter the Claimant's Date of Birth (mm/dd/yyyy).

**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.



# Completing the Surgical Package Template (3)

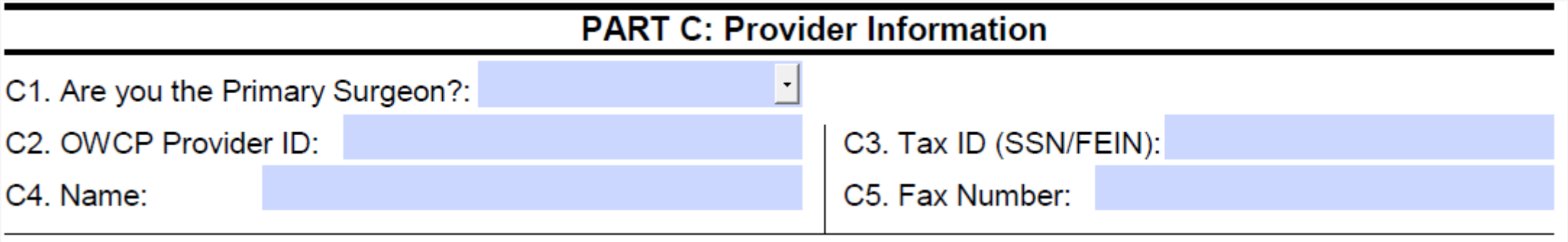
**C1.** Select the appropriate option (YES or NO), if the primary surgeon is completing this form.

**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)

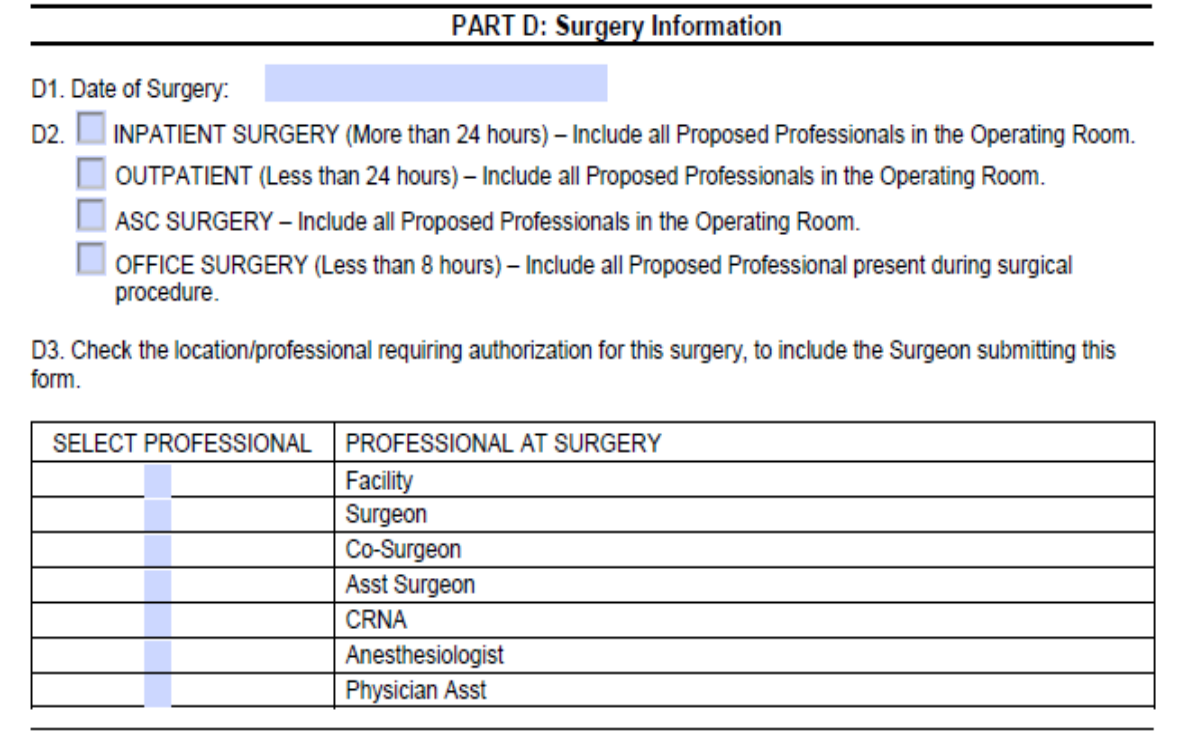


# Completing the Surgical Package Template (4)

**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 professional types involved in the surgery including the surgeon requesting the authorization.
- Facility
- Surgeon
- Co-Surgeon
- Assistant Surgeon (AS)
- Certified Registered Nurse Anesthetist (CRNA)
- Anesthesiologist
- Physician Assistant (PA)



**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 |
|---|---|
| | Facility |
| | Surgeon |
| | Co-Surgeon |
| | Asst Surgeon |
| | CRNA |
| | Anesthesiologist |
| | Physician Asst |

**Note:** One authorization will cover all professional types.

# Completing the Surgical Package Template (5)

**E1.** Enter the specific body part to be treated.

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

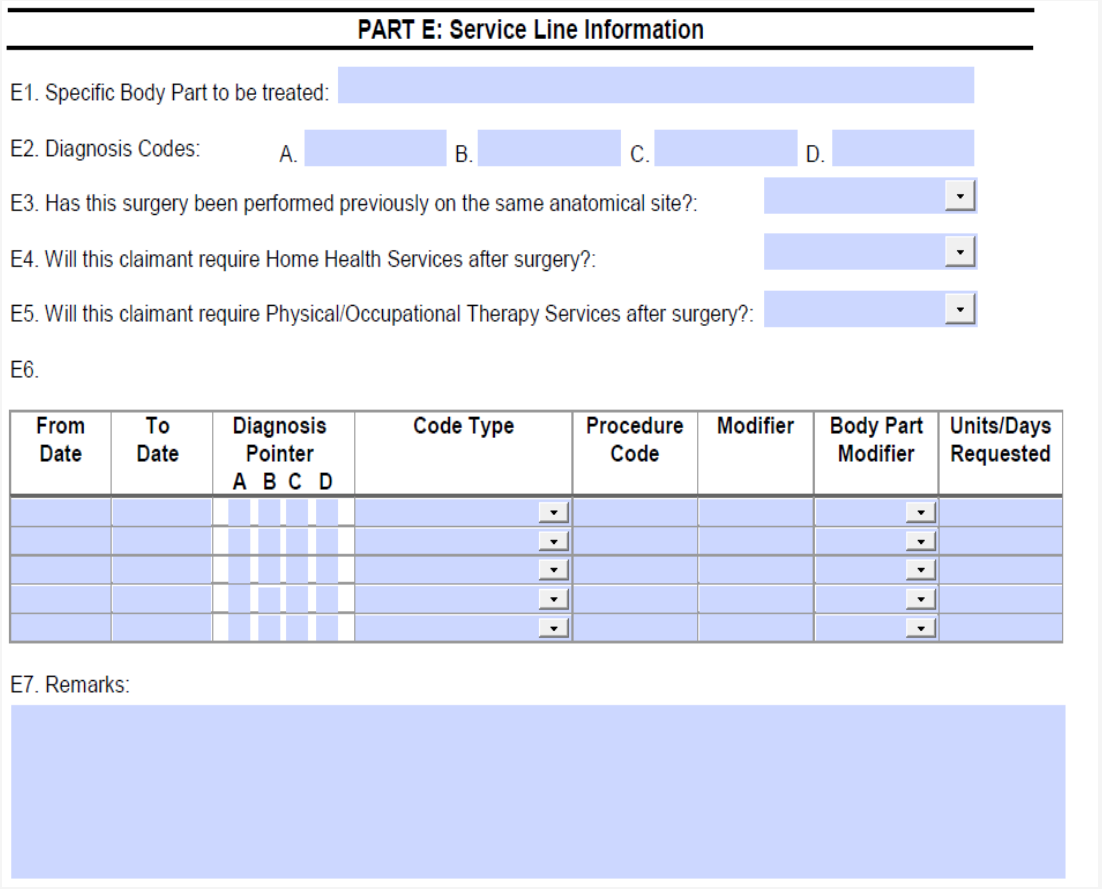
- ICD-9 code is applicable if date of service is on or prior to September 30, 2015. Use ICD-10 code if date of service is on or after October 1, 2015.

**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.



**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 |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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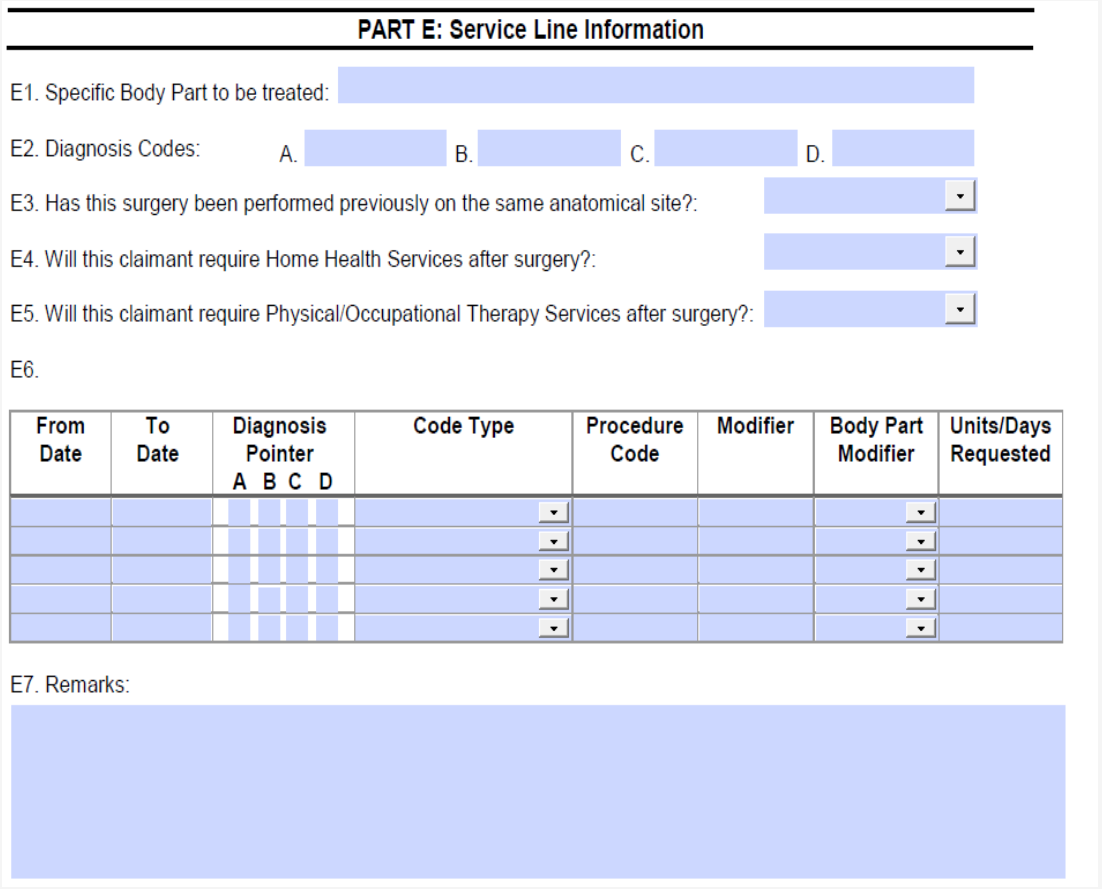
E7. Remarks:

# Completing the Surgical Package Template (6)

**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 or HCPCS).
- Enter the Procedure Code (valid code range 10021-69990.)
- Enter the procedure Modifier (if applicable).
- Select a Body Part Modifier option:
  LT (Left), RT (Right) or 50 (Bilateral).
- Enter the number of Units/Days Requested.

**E7.** Enter any additional remarks.



**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 |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
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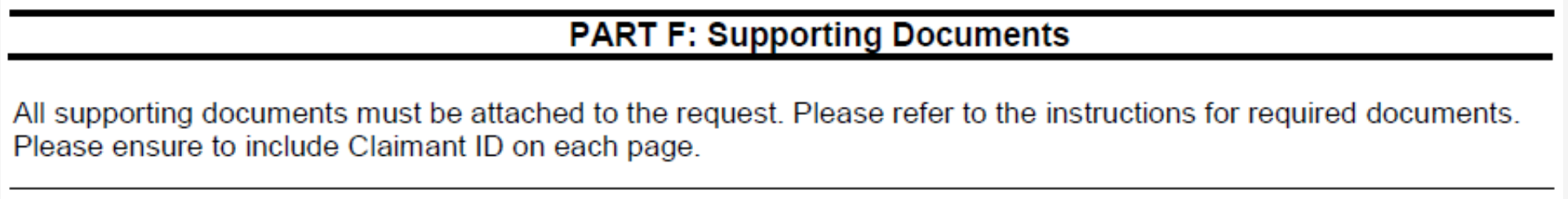
| | | | | | | | |
| | | | | | | | |

E7. Remarks:

# Completing the Surgical Package Template (7)

Attach any supporting documentation needed.

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



**PART F: Supporting Documents**

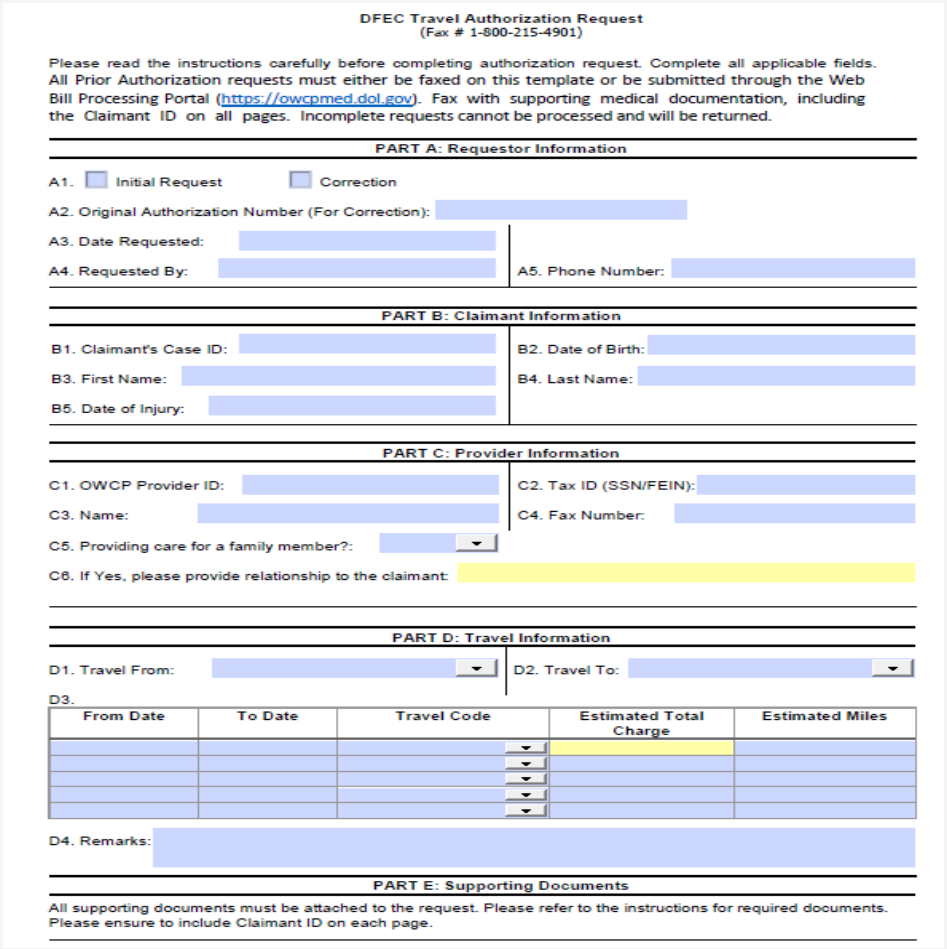
All supporting documents must be attached to the request. Please refer to the instructions for required documents. Please ensure to include Claimant ID on each page.

# Travel Template

# Travel Template (1)

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

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

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 (1)

**A1.** Select an option:

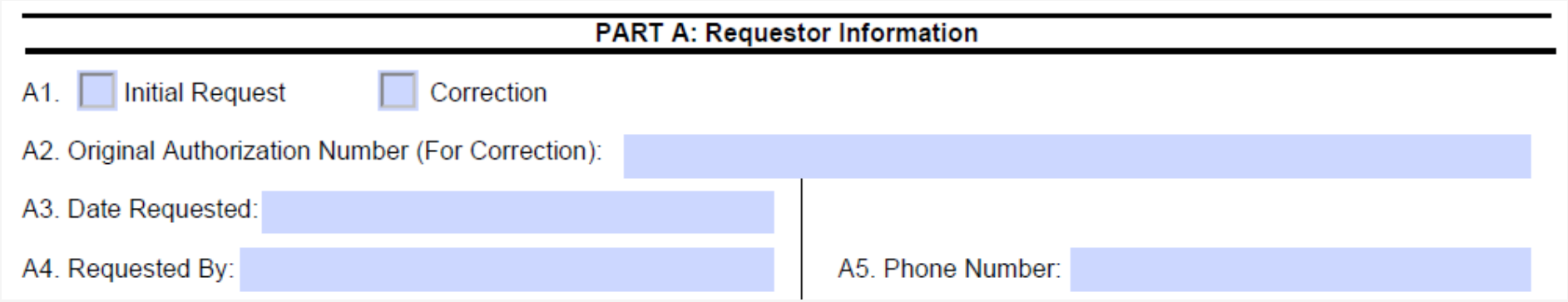
- Initial Request (new or first time requesting an authorization for travel).
- Correction (to update or correct an authorization that is currently on file).

**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 (2)

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

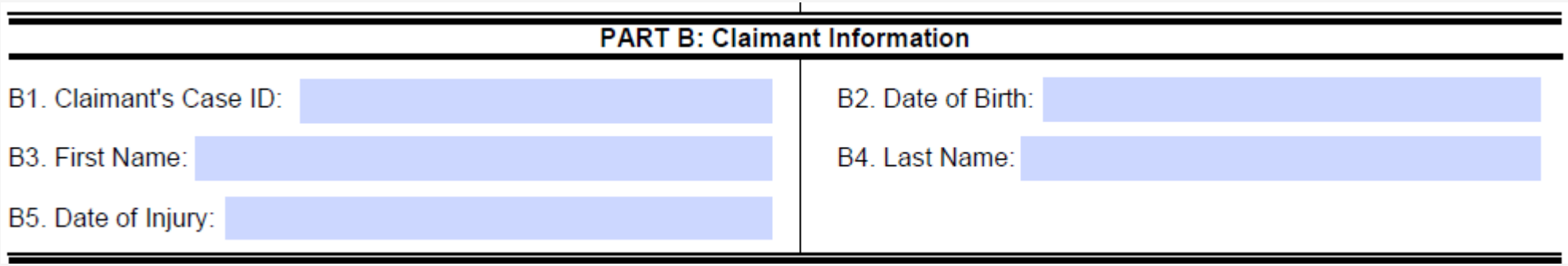
**B2.** Enter the Claimant's Date of Birth (mm/dd/yyyy).

**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.



# Completing the Travel Template (3)

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

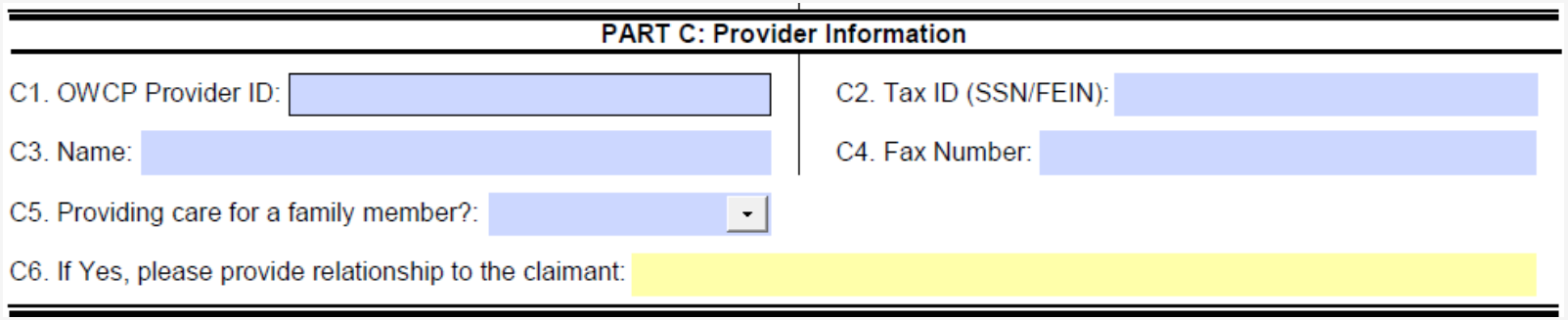
**C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.

**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 (4)

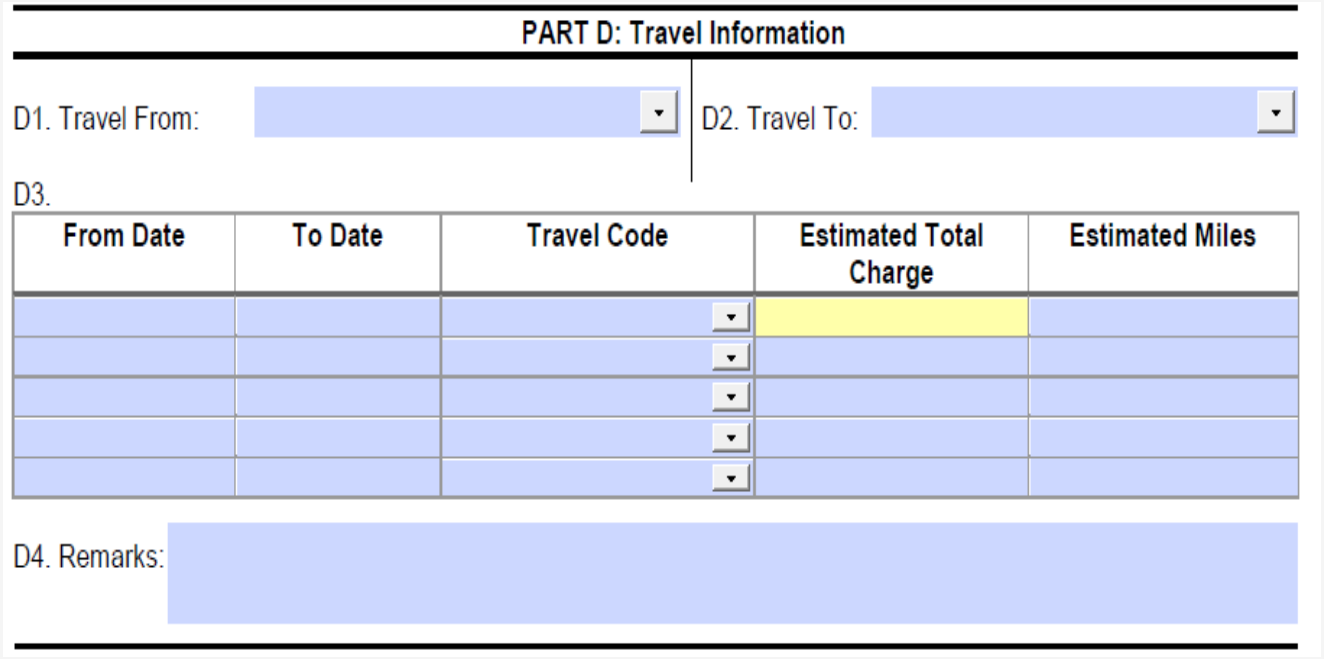
**D1.** Select the location where the travel started from.

**D2.** Select the location where the travel ended.

**D3.**

- Enter the travel from and to date.
- Enter the travel code or codes.
- 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:

D2. Travel To:

D3.

| From Date | To Date | Travel Code | Estimated Total Charge | Estimated Miles |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

D4. Remarks:

# Completing the Travel Template (5)

Attach Receipts or Invoices to confirm the estimated total charge.

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

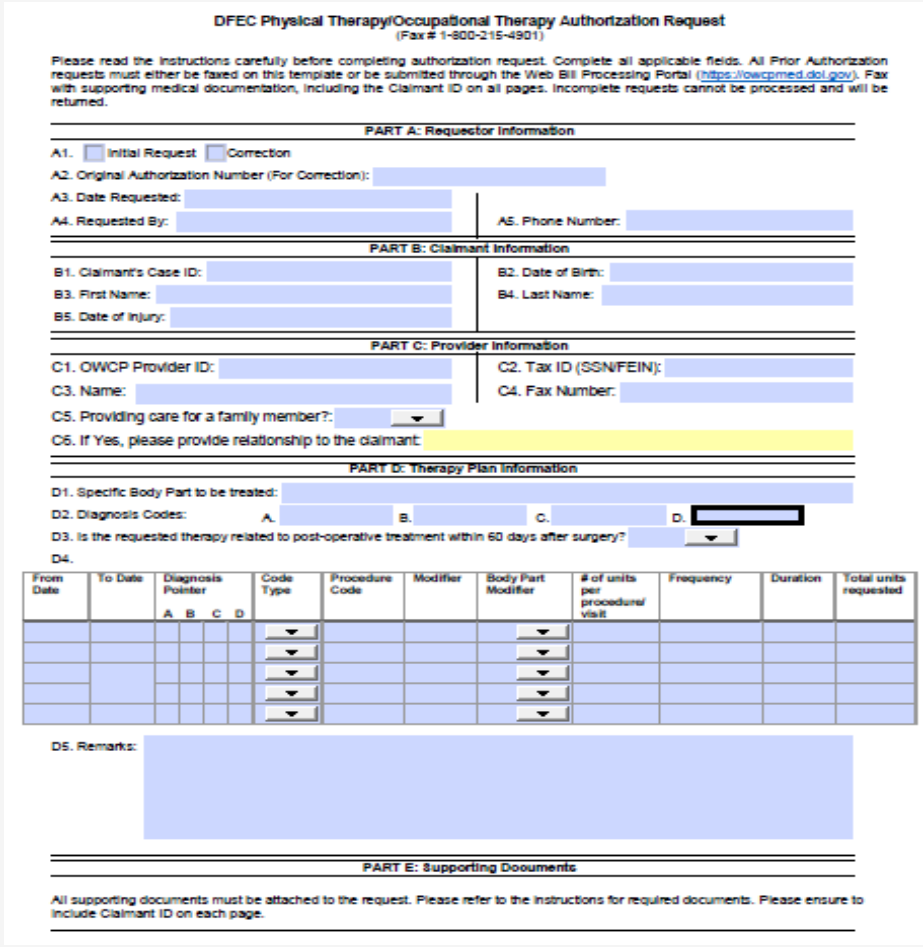
**PART E: Supporting Documents**

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 (1)

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 (A B C D) | Code Type | Procedure Code | Modifier | Body Part Modifier | # of units per procedure/ visit | Frequency | Duration | Total units requested |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
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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 (1)

**A1.** Select an option:

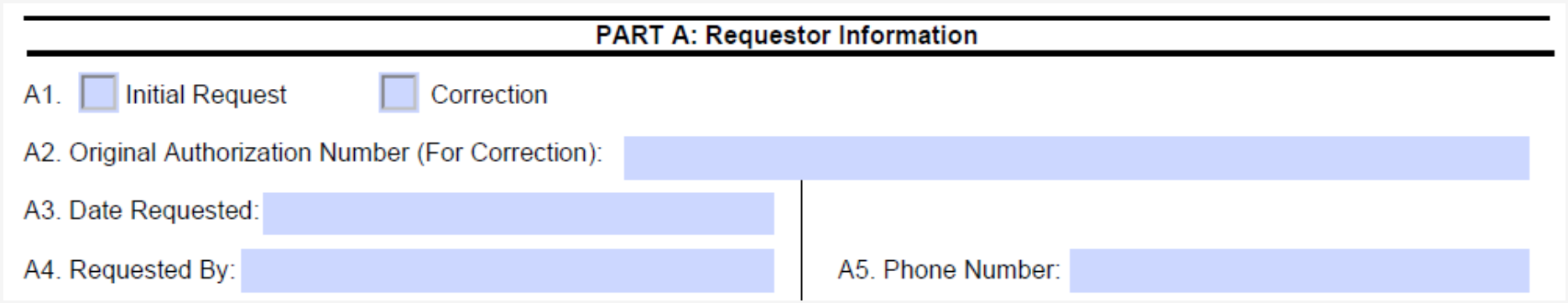
- Initial Request (new or first time requesting an authorization for physical therapy/occupational therapy).
- Correction (to update or correct an authorization that is currently on file).

**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 (2)

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

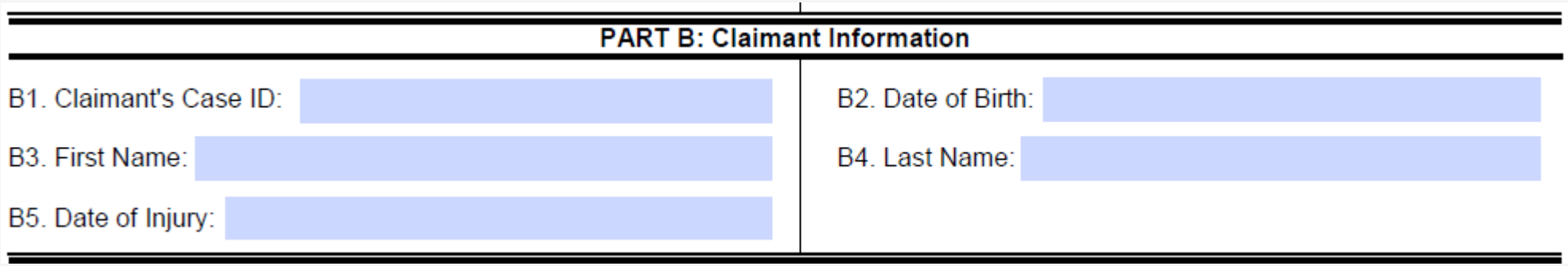
**B2.** Enter the Claimant's Date of Birth (mm/dd/yyyy).

**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:

B2. Date of Birth:

B3. First Name:

B4. Last Name:

B5. Date of Injury:

# Completing the Physical Therapy/Occupational Therapy Template (3)

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

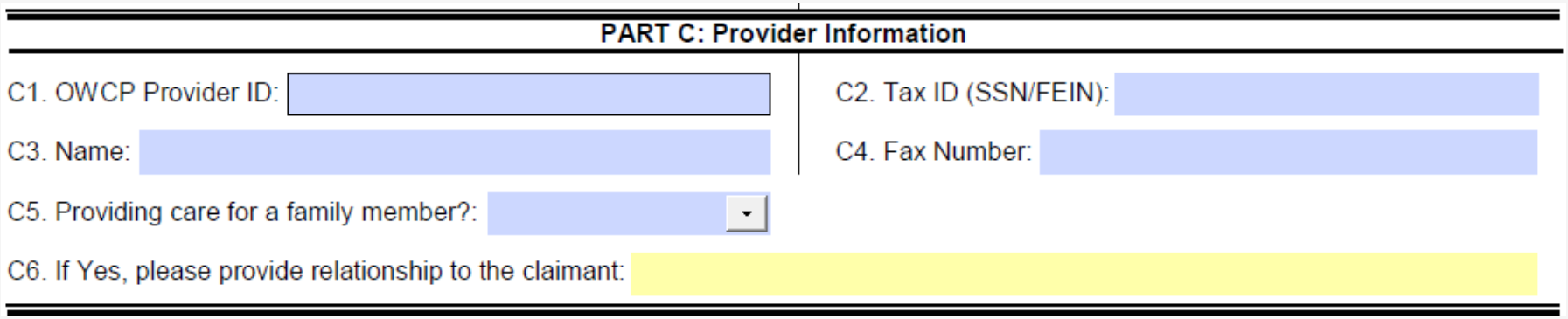
**C2.** Enter the provider's Social Security Number (SSN) or Federal Employer Identification Number (FEIN) that is associated with the Provider ID in C1.

**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 (4)

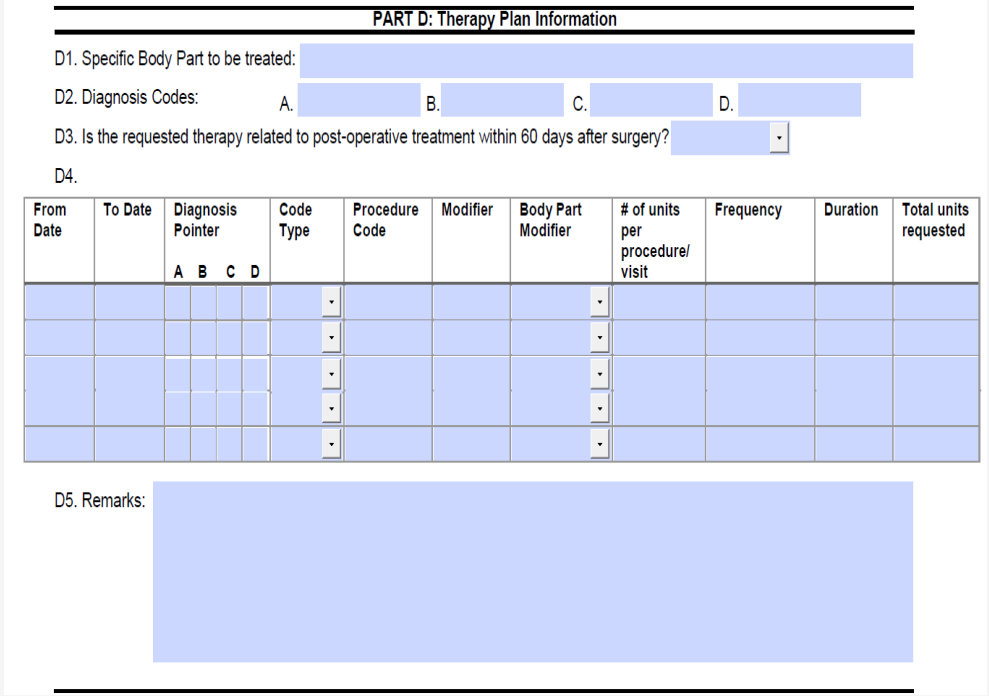
**D1.** Enter the specific body part to be treated.

**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 A B C D | Code Type | Procedure Code | Modifier | Body Part Modifier | # of units per procedure/ visit | Frequency | Duration | Total units requested |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
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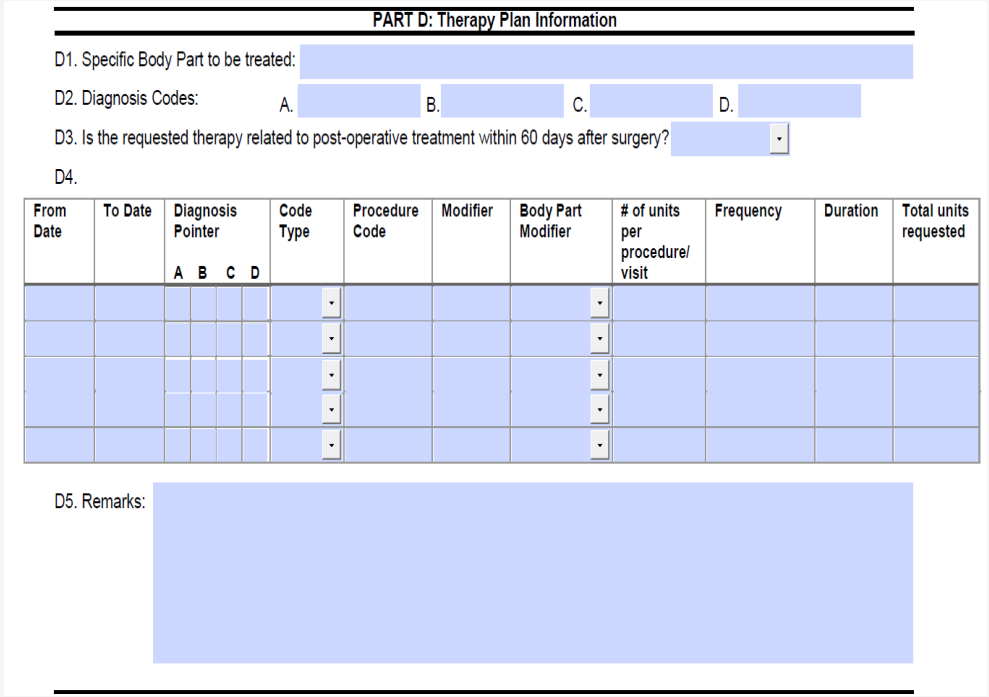
D5. Remarks:

# Completing the Physical Therapy/Occupational Therapy Template (5)

**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).
- 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 A B C D | Code Type | Procedure Code | Modifier | Body Part Modifier | # of units per procedure/ visit | Frequency | Duration | Total units requested |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
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D5. Remarks:

# Completing the Physical Therapy/Occupational Therapy Template (6)

- 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 through:
  - **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 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!