Print Reset

Rehabilitative Therapies Authorization Request

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

Note: Please read the instructions carefully before completing this authorization request. Complete all applicable fields. All requests with supporting documentation must either be faxed to 1-800-882-6147 or be submitted through the Web Bill Processing Portal (*https://owcpmed.dol.gov*). Please include the Claimant Case ID on all pages. Incomplete requests cannot be processed and will be returned.

OMB Control No: 1240-0060
Expiration Date: 05/31/2024

PART A: Requestor Information

A1. ☐ Initial Request ☐ Re-Authorization ☐ Amendment ☐ Correction

A2. Original Authorization Number (For Correction):

A3. Date Requested:

A4. Requested By:

A5. Phone Number:

PART B: Claimant Information

B1. Claimant's Case ID:

B2. Date of Birth:

B3. First Name:

B4. Last Name:

PART C: Provider Information

C1. OWCP Provider ID:

C2. Tax ID (SSN/FEIN):

C3. Name:

C4. Fax Number:

C5. Providing care for a family member?:

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

PART D: Therapy Plan Information

D1. Place of Service (Select one)

☐ Home ☐ Facility ☐ Office ☐ Outpatient

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

D3.

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

D4. Remarks:

PART E: Supporting Documents

All supporting documents must be attached to the request. Failure to include supporting documentation may result in a delay in processing or denial. See instructions for required documents. Please ensure to include claimant's case ID on each page.

Instructions

Part A: Requestor Information		
A1.	Select an appropriate option for initial, re-authorization, amendment or correction request Initial Request – New or first-time request Re-Authorization – to request same level of care as the previous request Amendment – To request different level of care Correction – To update or correct erroneous data elements	Required
A2.	Type or print an original authorization number if correction request is being submitted. If you don't have authorization number, provide details about the original authorization, such as Claimant's Case ID, procedure code, date of service, requested units etc. if they are being changed in Remarks field	
A3.	Type or print date on which this template is being completed	Required
A4.	Type or print name of the person requesting an authorization	Required
A5.	Type or print phone number of the person requesting an authorization	

Part B: Claimant Information		
B1.	Type or print claimant's case ID	Required
B2.	Type or print claimant's date of birth (mm/dd/yyyy)	Required
B3.	Type or print claimant's first name	Required
B4.	Type or print claimant's last name	Required

Part C: Provider Information		
C1.	Type or print service rendering provider's OWCP ID	Required
C2.	Type or print provider's Tax ID (SSN or FEIN)	Required
C3.	Type or print provider's name	Required
C4.	Type or print fax number. If entered, this fax number will be used for communication related to this authorization request. Leave it blank if fax number was provided during provider enrollment.	
C5.	Select an option if providing care for a family member • Yes • No	Required
C6.	Type or print relationship to the claimant	Required if "Yes" is selected in field C5

Part D: Therapy Plan Information		
D1.	Select place of service from the following options: • Home • Facility • Office • Outpatient	Required
D2.	Type or print ICD-09 or ICD-10 diagnosis codes for which services are being rendered, up to 4 codes are allowed. ICD-9 code is applicable if date of service is prior to 09/30/2015. Use ICD-10 code if date of service is after 10/01/2015.	Required
D3.	Service lines	
	Type or print beginning date of the service	Required
	Type or print end date of the service	Required
	Select diagnosis code pointer from the diagnosis codes listed in Part D: A, B, C, D Select all applicable options.	Required
	Select code type from following options: • CPT Procedure Code • HCPCS Procedure Code	Required
	Type or print applicable procedure code	Required
	Type or print number of units per visit or procedure	Required
	Type or print frequency of service requested. E.g. 3 times a week	Required
	Type or print duration of service requested. E.g. 4 weeks	Required
	Type or print number of total units requested. Multiply # of Units Requested (per procedure) x	Required

	Frequency Requested x Duration = Total Units Requested. E.g. # of unit per visit is 2, if frequency is 3 times a week, duration is 4 weeks, then total unit should be 24.	
D4.	Type or print additional notes or remarks, if any	

Part E: Supporting Documentation		
	Therapy Evaluation, Letter of Medical Necessity (LMN). Evidence of Face to Face exam, and any medical documentation supporting the need for therapy as it relates to the accepted condition(s). If services will be provided in the home, LMN must indicate whether or not claimant is homebound.	Required

PRIVACY ACT STATEMENT

The Privacy Act of 1974, as amended (5 U.S.C. 552a) authorizes OWCP to ask you for information needed in the administration of the EEOICPA program. Authority to collect information is in 42 USC 7384d, 20 CFR 30.1 et seq. and E.O. 13179. The information we obtain is used to decide if the services and supplies being billed for are covered by the program and to insure that proper payment is made. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) at issue will prevent payment of the bill. Failure to supply the claim number or CPT codes will delay payment or may result in rejection of the authorization request because of incomplete information.

We are authorized to request a taxpayer identification number (TIN) or Social Security Number (SSN) under the Debt Collection Improvement Act of 1996, 31 U.S.C. 7701(c)(1), which mandates us to require persons who are doing business with a Federal agency to furnish a TIN or SSN. The SSN or TIN, and other information maintained by us may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor system DOL/OWCP-11 published in the Federal Register, Vol. 81, page 25868, April 29, 2016, or as updated and republished.

You should be aware that P.L. 100-503, the “Computer Matching and Privacy Protection Act of 1988,” permits the government to verify information by way of computer matches.

PUBLIC BURDEN STATEMENT

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1240-0060. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) requested will prevent payment of the bill. We estimate that it will take an average of ten minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient’s records and entering the data onto the form. This time is based on familiarity with standardized coding structures. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Department of Labor, Office of Workers’ Compensation Programs, Division of Energy Employees Occupational Illness Compensation, Room C3321, 200 Constitution Avenue NW, Washington, DC 20210. D**O NOT SEND THE COMPLETED FORM TO THIS OFFICE**.