Print Reset

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

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.

Instructions

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Part A: Requestor Information		
A1.	Select an appropriate option for initial or correction request Initial Request – New or first-time request 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
B5.	Type or print claimant's date of injury (mm/dd/yyyy)	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: Service Plan Information		
D1.	Type or print a specific body part that requires treatment,	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 on/prior to 09/30/2015. Use ICD-10 code if date of service is on/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 qualifier from following options: • CPT Procedure Code • HCPCS Procedure Code	Required
	Type or print applicable procedure code	Required
	Select body part modifier from following options:	

	• RT – Right Side • LT – Left Side • 50 – Bilateral	
	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 total number of units requested. E.g. If frequency is 3 times a week, duration is 4 weeks then total units should be 12	Required
D4.	Type or print additional notes or remarks, if any If correction request is being submitted and you don't have the original authorization number, provide details about the original authorization, such as claimant ID, procedure code, date of service, requested units etc. if they are being changed	

Part E: Supporting Documentation		
	Supporting medical documentation, if applicable	