

**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.

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**PART A: Requestor Information**

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A1. Initial Request                      Correction

A2. Original Authorization Number (For Correction):

A3. Date Requested:

A4. Requested By:

A5. Phone Number:

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**PART B: Claimant Information**

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B1. Claimant's Case ID:

B2. Date of Birth:

B3. First Name:

B4. Last Name:

B5. Date of Injury:

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**PART C: Provider Information**

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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:

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**PART D: Travel Information**

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D1. Travel From:

D2. Travel To:

D3.

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

D4. Remarks:

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**PART E: Supporting Documents**

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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.

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## Instructions

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| Part A: Requestor Information |   |          |
|-------------------------------|---|----------|
| A1.                           | Select an appropriate option for initial or correction request<br><br>Initial Request – New or first-time request<br>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 |   | Required, if completed by provider.<br>Leave this section blank, if completed by claimant. |
|------------------------------|---|--|
| C1.                          | Type or print service rendering provider's OWCP ID  |  |
| C2.                          | Type or print provider's Tax ID (SSN or FEIN)   |  |
| C3.                          | Type or print provider's name   |  |
| 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 <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>  |  |
| C6.                          | Type or print relationship to the claimant  | Required if "Yes" is selected in field C5  |

| Part D: Travel Information |  |          |
|----------------------------|--|----------|
| D1.                        | Select origin of travel from following options: <ul style="list-style-type: none"> <li>• Home</li> <li>• Hospital</li> <li>• Lab</li> <li>• Office/Clinic</li> <li>• Pharmacy</li> <li>• Work</li> </ul> | Required |
| D2.                        | Select destination of travel from following options: <ul style="list-style-type: none"> <li>• Home</li> <li>• Hospital</li> </ul>  | Required |

|     |   |          |
|-----|---|----------|
|     | <ul style="list-style-type: none"> <li>• Lab</li> <li>• Office/Clinic</li> <li>• Pharmacy</li> <li>• Work</li> </ul>  |          |
| D3. | Service lines (Please enter each procedure code on a separate line.)  |          |
|     | Type or print beginning date of the service   | Required |
|     | Type or print end date of the service   | Required |
|     | Select travel code from following options: <ul style="list-style-type: none"> <li>• A0100 - Taxi</li> <li>• A0110 - Bus, intra- or interstate carrier</li> <li>• A0120 - Mini-Bus, mountain area transports, and other transports</li> <li>• A0130 - Wheelchair Van</li> <li>• A0140 – Air Travel</li> <li>• A0170 - Transport Parking Fees/Tolls</li> <li>• A0180 – Lodging (applicable only for claimant)</li> <li>• A0190 – Meals (applicable only for claimant)</li> <li>• A0080 – Total Trip Miles (with no vested interest)</li> <li>A0090 – Total Trip Miles (with vested interest)</li> </ul> | Required |
|     | Type or print total estimated charges for codes A0100 to A0190 if dollar amount is greater than \$75.00. They are authorized based on private transportation total charges  |          |
|     | Type or print estimated miles for code A0080 and A0090 if greater than 100 miles. Travel service is authorized based on total round trip miles  |          |
| D4. | Type or print additional notes or remarks, if any   |          |

|   |   |  |
|---|---|--|
| <b>Part E: Supporting Documentation</b> |   |  |
|   |   |  |
|   | Supporting medical documentation, if applicable |  |