Print Reset

Office of Workers' Compensation Programs (OWCP)

Authorization Request Supporting Documents Cover Sheet

Program Name: Select *

Authorization Request Number: * (10 digits)

Claimant Case ID: * (min 3 and max 16 characters)

Claimant Name: (First Name and Last Name)

OWCP Provider ID: (9 digits)

THIS COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX/MAIL WITH ALL SUPPORTING DOCUMENTATION BEHIND THIS COVER SHEET.

DFEC	DEEOIC	DCMWC
U.S. Department of Labor OWCP/ DFEC PO Box 8300 London, KY 40742-8300 FAX to: 1- (800) 215-4901	U.S. Department of Labor OWCP/ DEEOIC PO Box 8304 London, KY 40742-8304 FAX to: 1- (800) 882-6147	U.S. Department of Labor OWCP/ DCMWC PO Box 8302 London, KY 40742-8302

Form: OWCP-PA-01