DFEC Authorization Templates

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  - General Medical
  - Home Health
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  - Surgical Package
  - Travel
  - Physical Therapy/Occupational Therapy
- Authorization Submission Methods

Overview

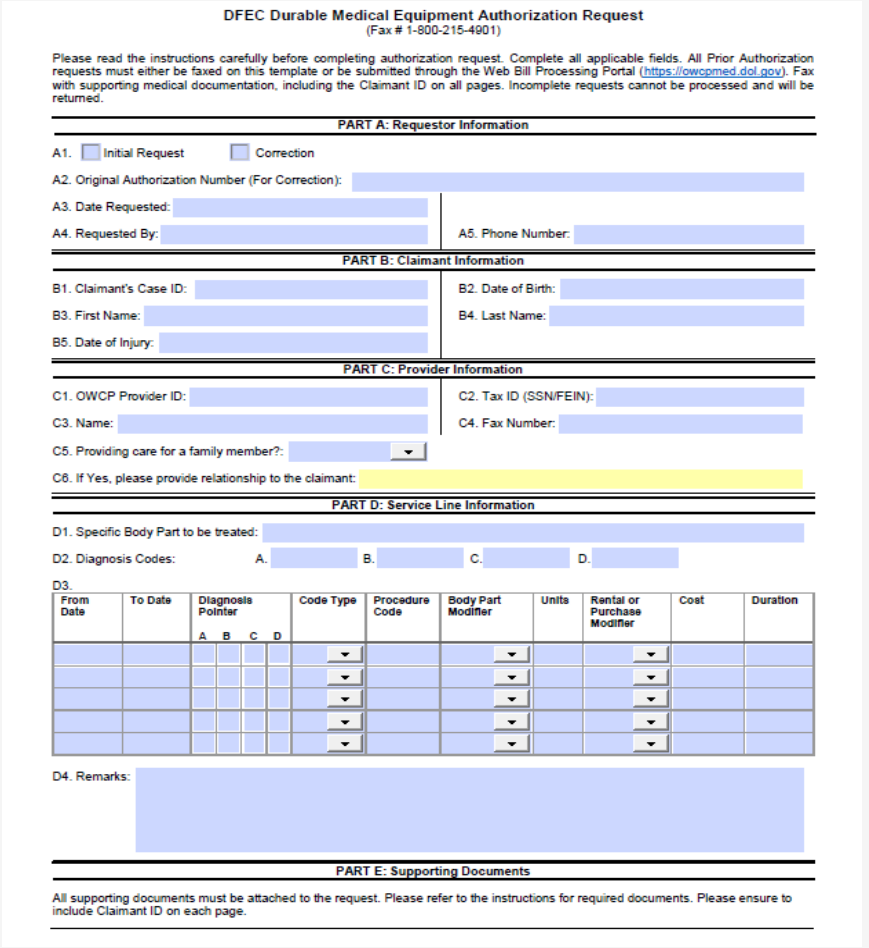
When claimants are treated for their work-related injuries and/or occupational diseases, providers are required to secure an approved prior authorization for certain services. DFEC provides the prior authorization request templates for Provider use when requesting prior authorization. These templates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

Providers can determine whether a service requires a prior authorization by using the Claimant Eligibility feature available within the WCMBP System's Provider Portal @ https://owcpmed.dol.gov or may speak with a customer service representative @ 844-493-1966.

Durable Medical Equipment Template

Durable Medical Equipment Template

Requests for Durable Medical Equipment that are 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.

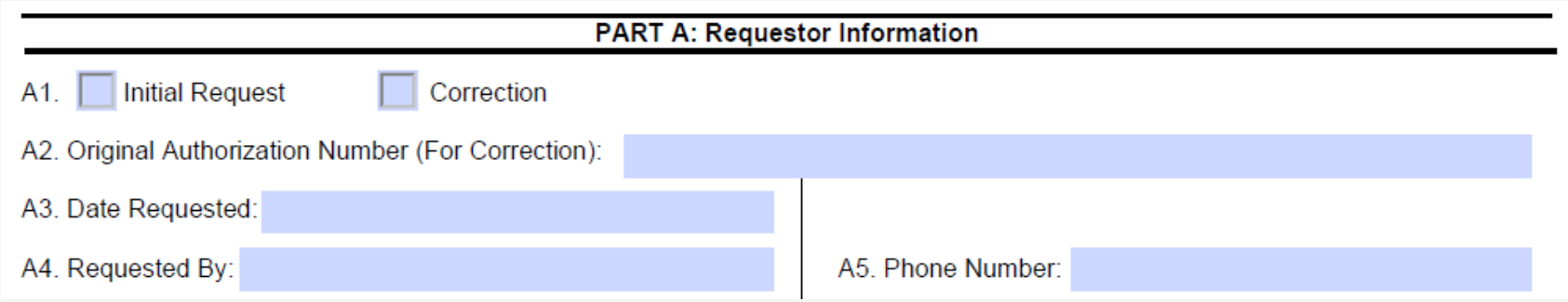
From Date	To Date	Diagnosis Pointer A B C D	Code Type	Procedure Code	Body Part Modifier	Units	Rental or Purchase Modifier	Cost	Duration

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


PART A: Requestor Information

A1. ☐ Initial Request ☐ Correction

A2. Original Authorization Number (For Correction):

A3. Date Requested:

A4. Requested By:

A5. Phone Number:

A1. Select an option:

- Initial Request (new or first-time authorization request for DME).
- Correction (to correct/add additional service lines to 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

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

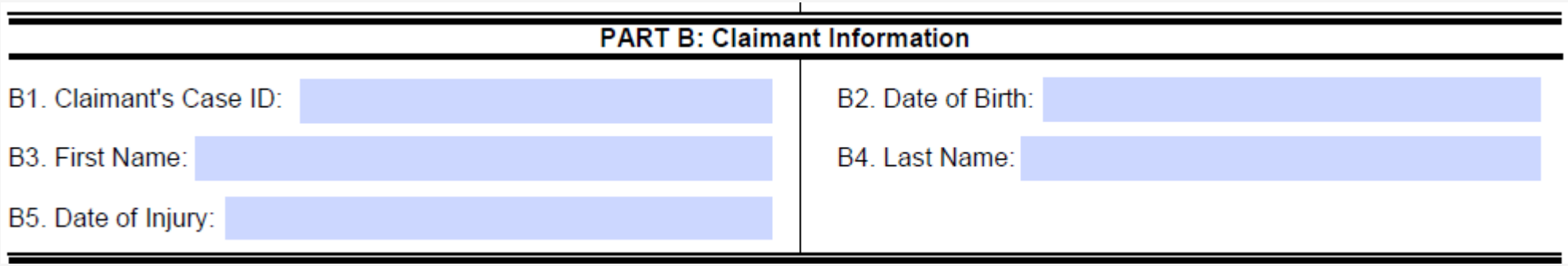
B2. Enter the Claimant's Date of Birth (mm/dd/yyyy).

B3. Enter the Claimant's First Name.

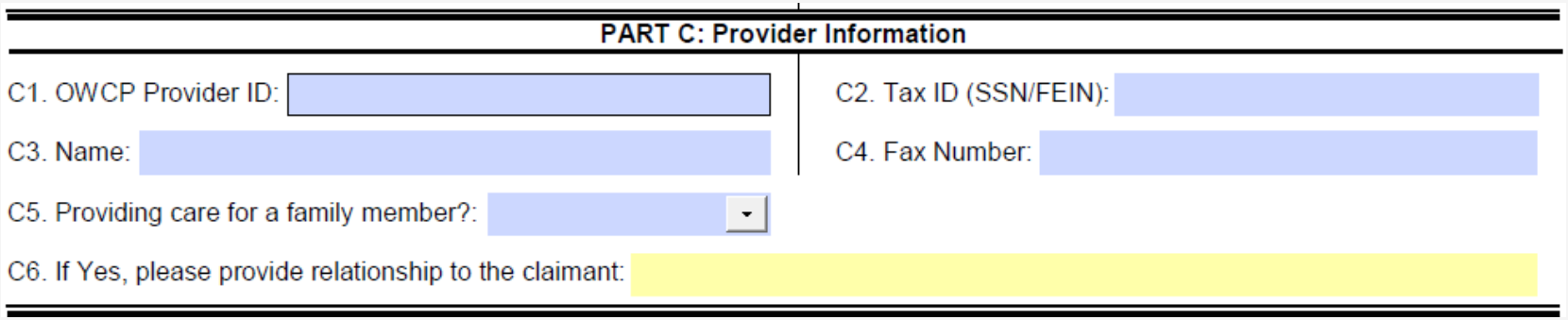
B4. Enter the Claimant's Last Name.

B5. Enter the Claimant's Date of Injury (mm/dd/yyyy).

Note: All fields in Part B are required.



Completing the Durable Medical Equipment Template



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) associated with the Provider ID entered in C1.

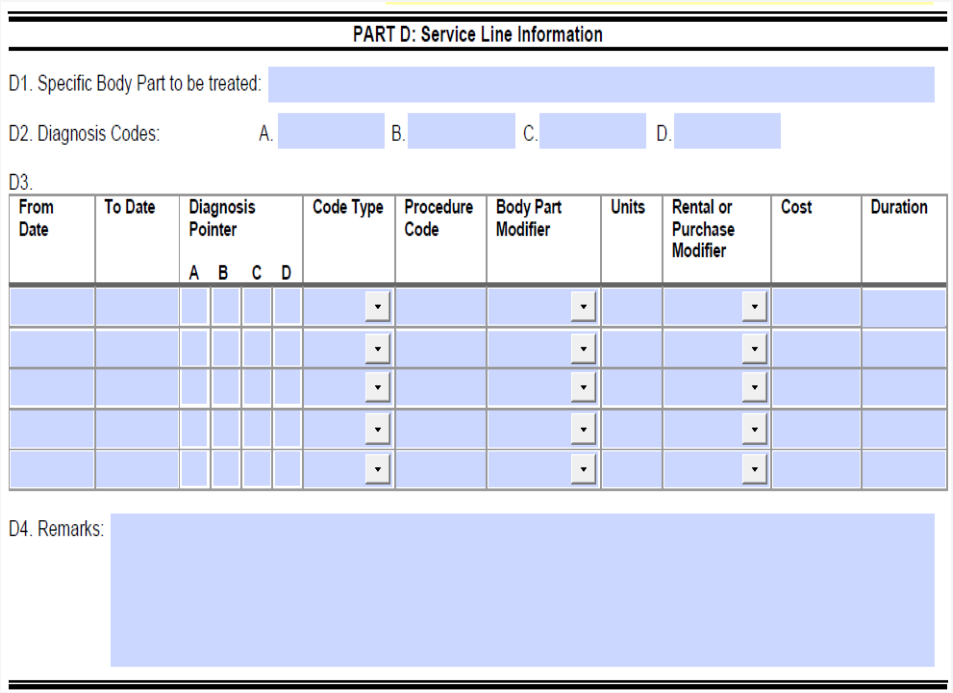
C3. Enter the Provider's Name.

C4. Enter a fax number to receive communication regarding the fax submitted. If the fax number is in the system under the providers profile, it can be left blank. (Not Required)

C5. Confirm if providing care for a family member or not.

C6. If you are providing care for a family member, state your relationship to the claimant. **(Only required if "Yes" was selected in C5.)**

Completing the Durable Medical Equipment Template



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

D4. Remarks:

D1. Enter the specific body part for the DME.
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 Diagnosis you want to point to from 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).
Select 50 if the equipment is for the back, neck or head area.
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)

Completing the Durable Medical Equipment 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.

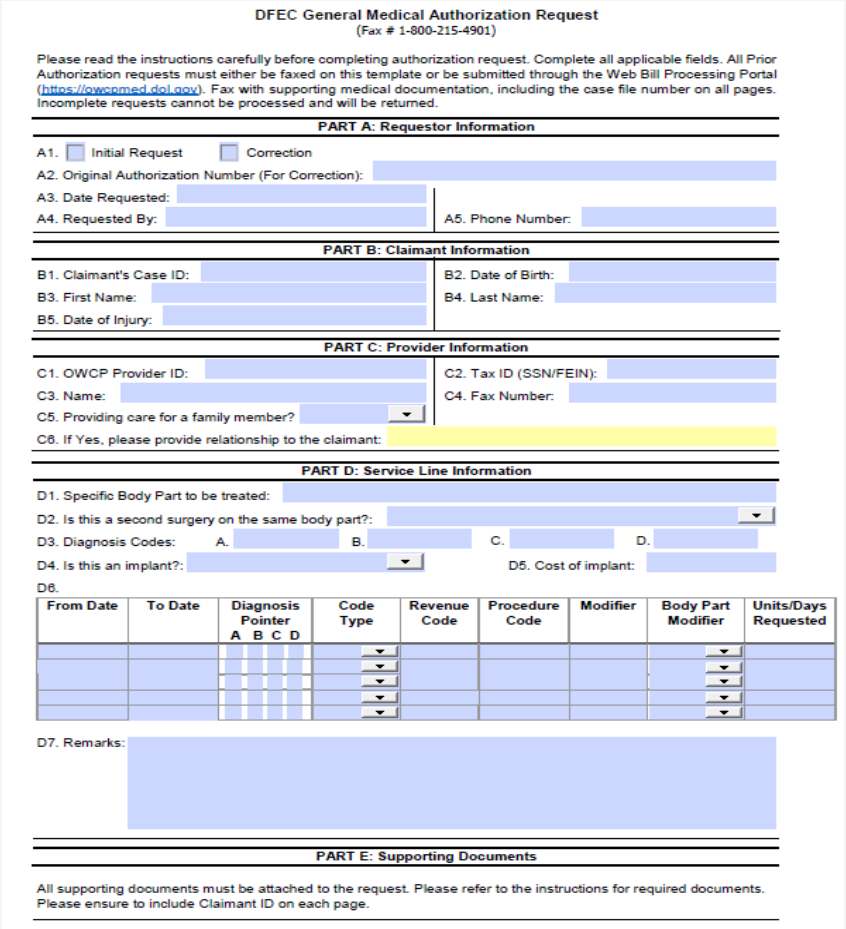
A prescription from the prescribing doctor, along with the treatment plan is required.

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

General Medical Template

General Medical Template

Requests for General Medical Services that are 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

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.

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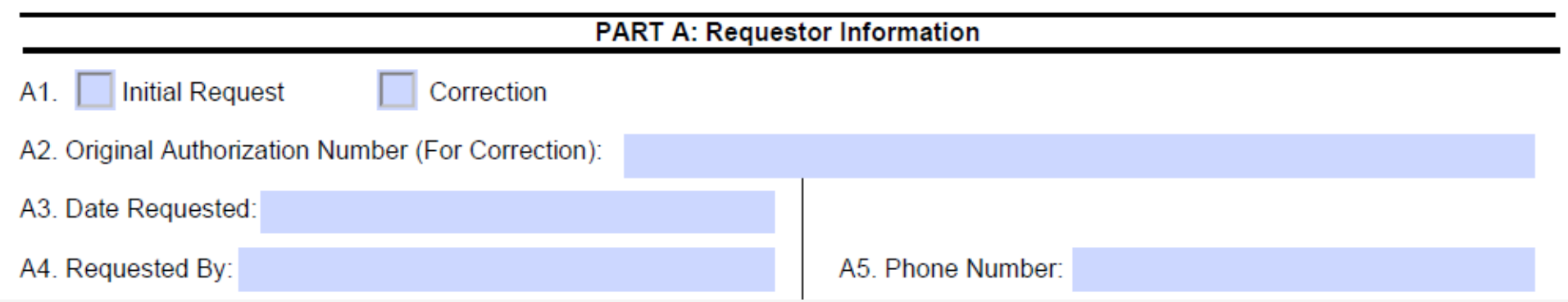
Completing the General Medical Template



A1. Select an option:

- Initial Request (new or first time requesting an authorization for general medical).
- Correction (to correct/add additional service lines to 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

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

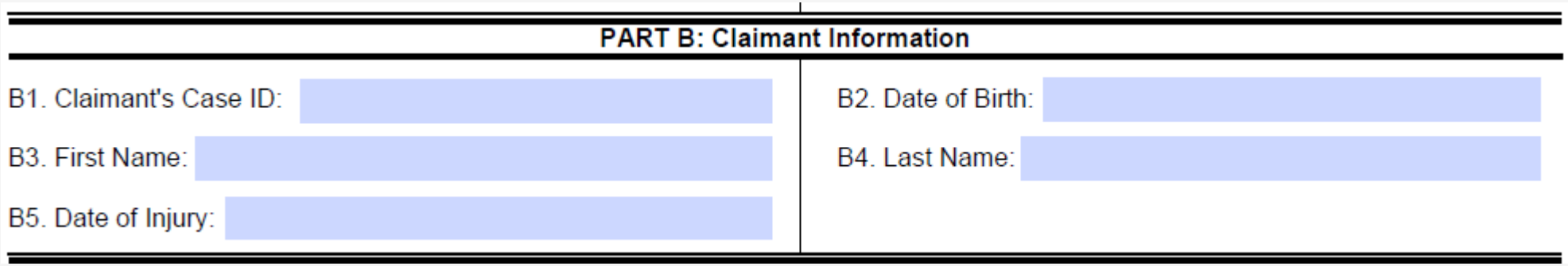
B2. Enter the Claimant's Date of Birth (mm/dd/yyyy).

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).

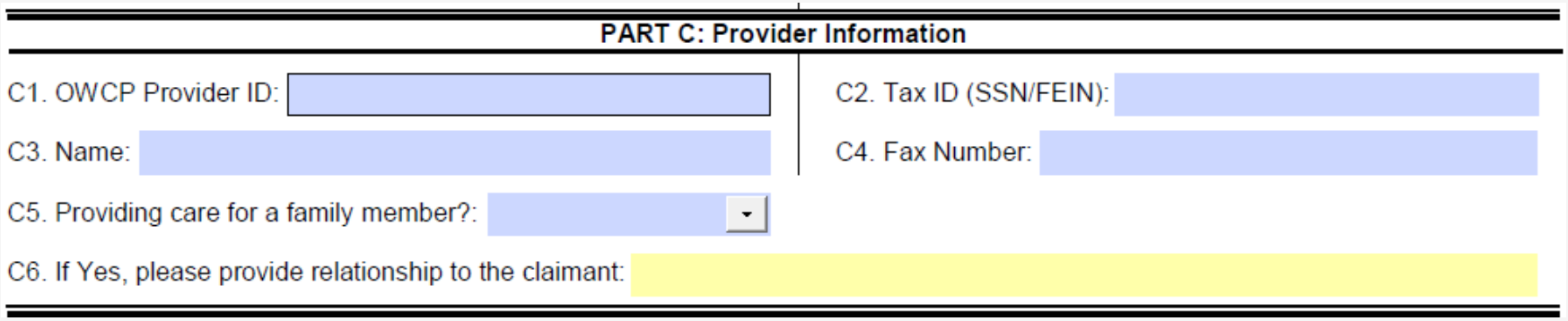
Note: All fields in Part B are required.



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 General Medical Template



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.

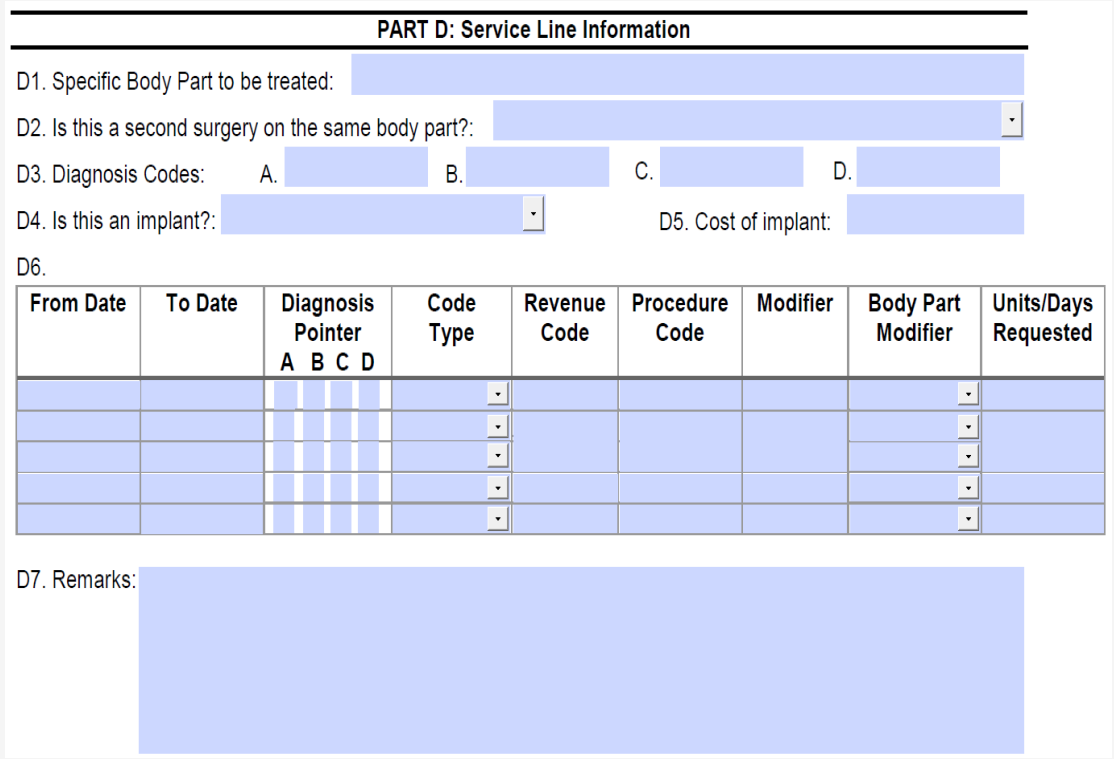
C3. Enter the Provider's Name.

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 for a family member, state your relationship to the claimant. **(Only required if" Yes" was selected in C5)**

Completing the General Medical Template



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

D7. Remarks:

D1. Enter the specific body part to be treated.

D2. State if this a second surgery to the same body part.

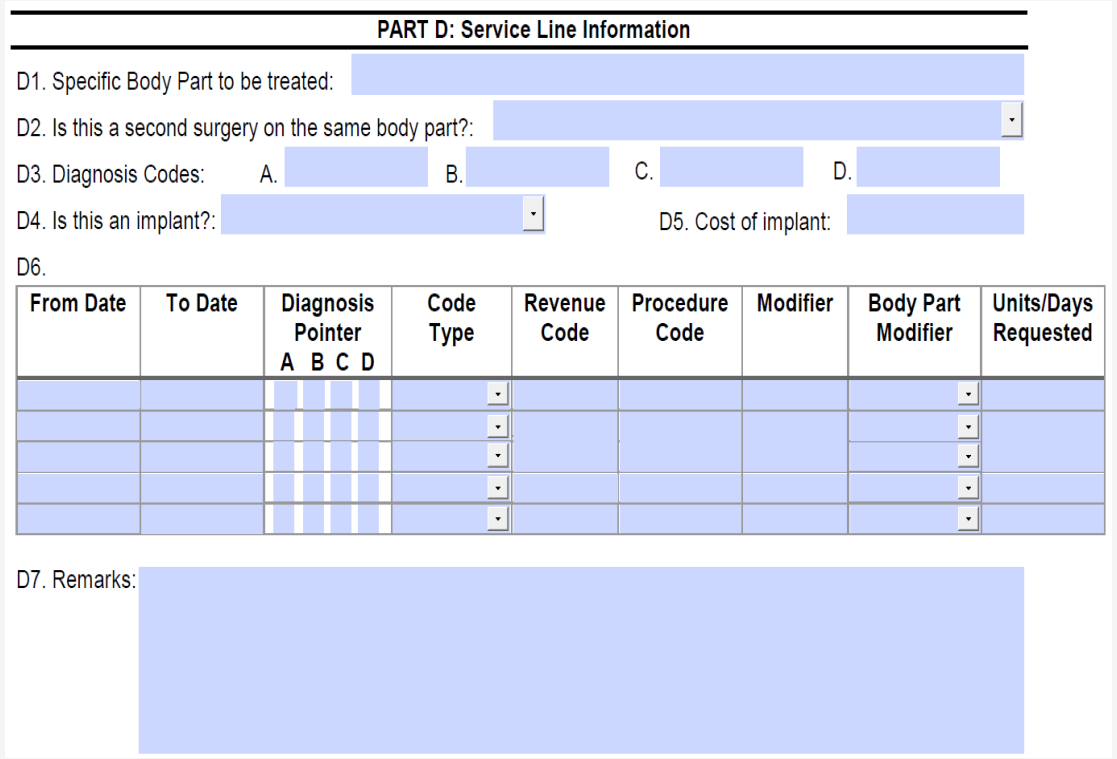
D3. Up to four ICD-9 or ICD-10 codes can be entered.

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

D4. State if this is an implant.

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

Completing the General Medical Template – Continued



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

D7. Remarks:

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). Select 50 if the service is for the back, neck or head area.
- Enter the Units/Days requested.

D7. Enter any additional remarks.

Completing the General Medical Template

Attach any supporting documentation that may help.

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

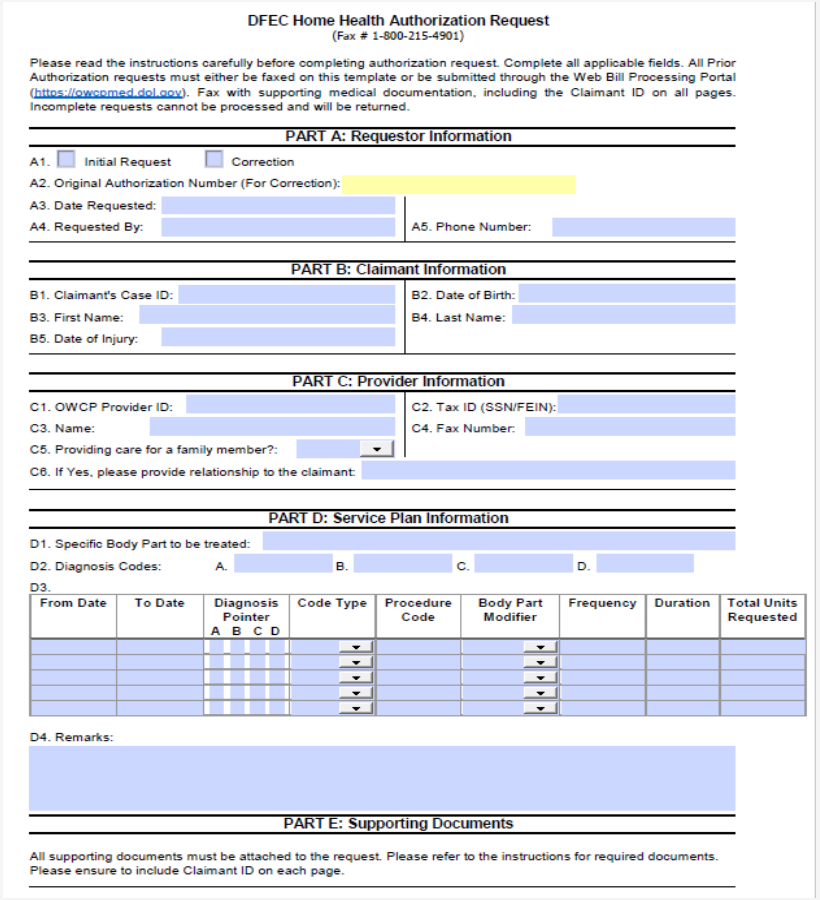
PART E: Supporting Documents

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

Requests for Home Health Services that are a 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.

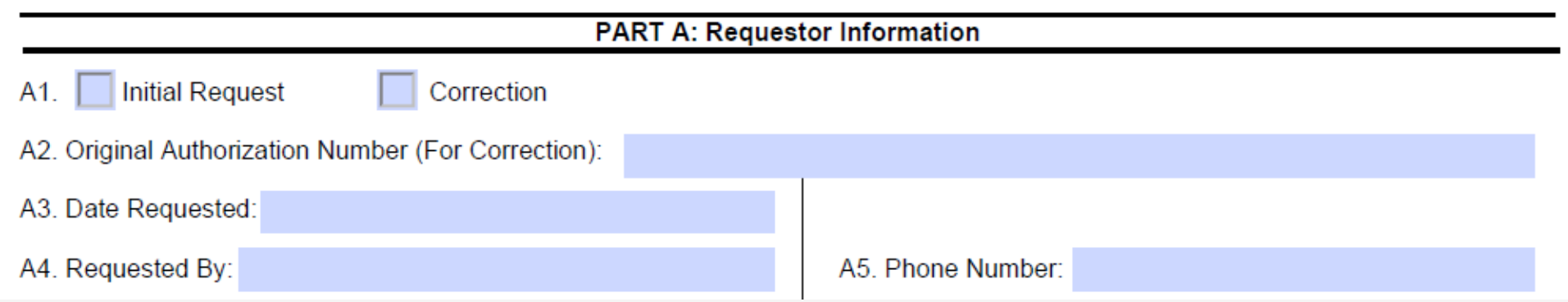
From Date	To Date	Diagnosis Pointer A B C D	Code Type	Procedure Code	Body Part Modifier	Frequency	Duration	Total Units Requested

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



A1. Select an option:

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

A2. If making a correction to an authorization that is on file, list the authorization number.

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

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

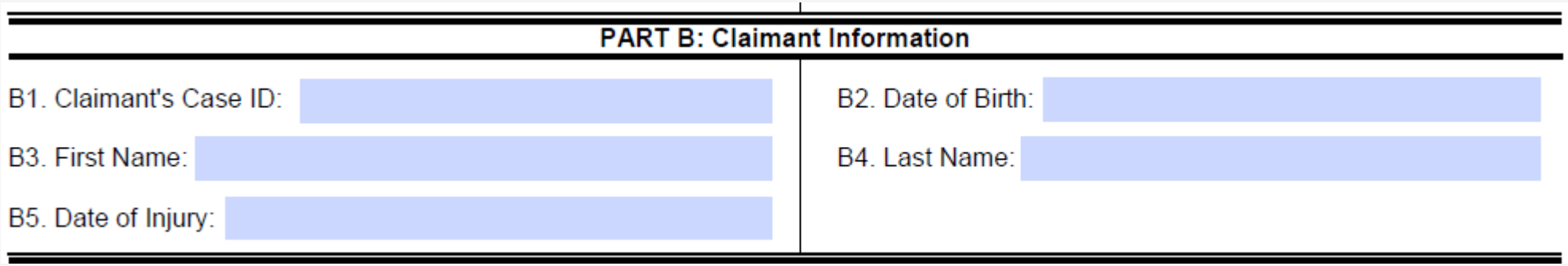
B2. Enter the Claimant's Date of Birth (mm/dd/yyyy).

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).

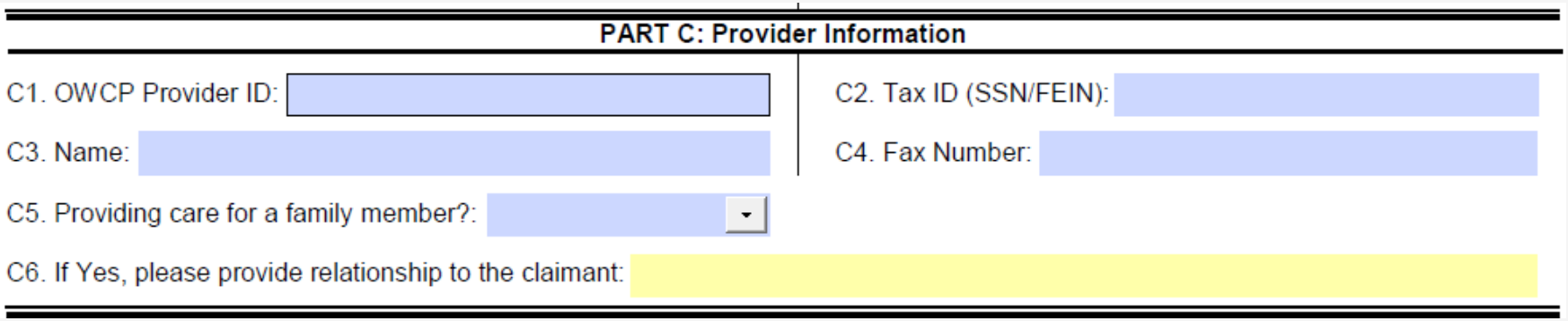
Note: All fields in Part B are required.



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 Home Health Template



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.

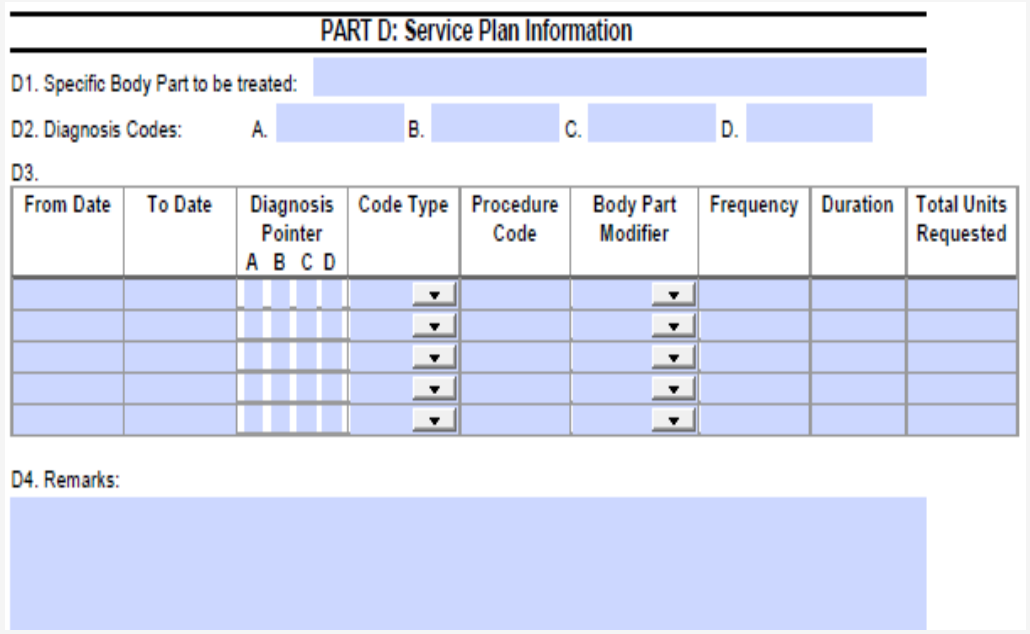
C3. Enter the Provider's Name.

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 for a family member, state your relationship to the claimant. **(Only required if Yes was selected in C5.)**

Completing the Home Health Template



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:

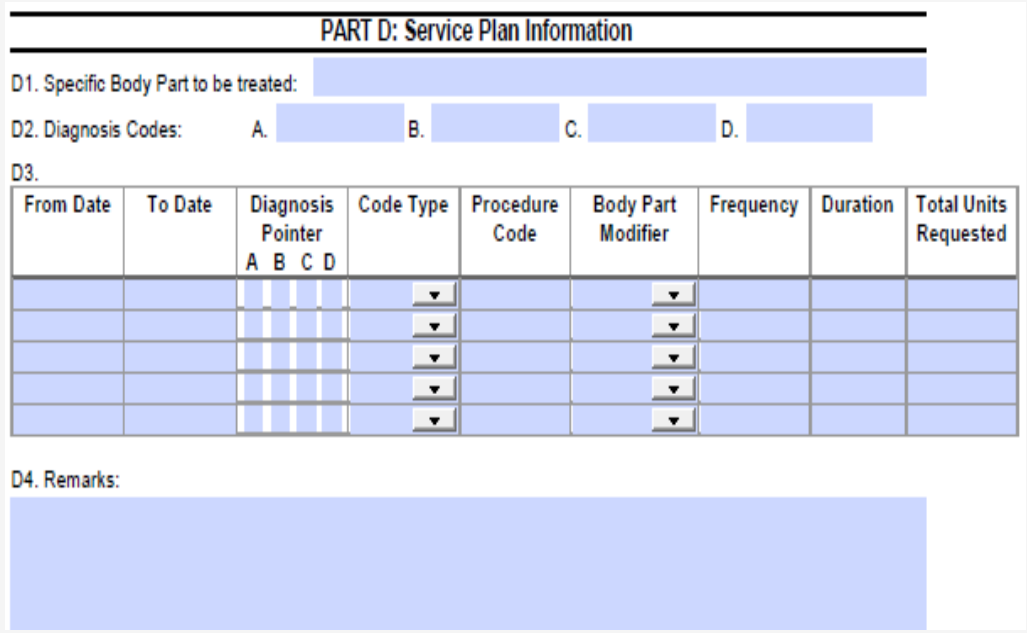
D1. Enter the specific body part to be treated.

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

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

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

Completing the Home Health Template – Continued



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:

D3.

- Enter the DOS range.
- Select the Diagnosis you want to point to from D2. Multiple pointers can be selected.
- Select Code Type (CPT/HCPCS).
- Enter the procedure code.
- Select a Body Part Modifier Option: LT (Left), RT (Right), or 50 (Bilateral). Select 50 if the service is for the back, neck, or head area.
- 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.

Completing the Home Health Template

Any supporting documentation will need to be attached.

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

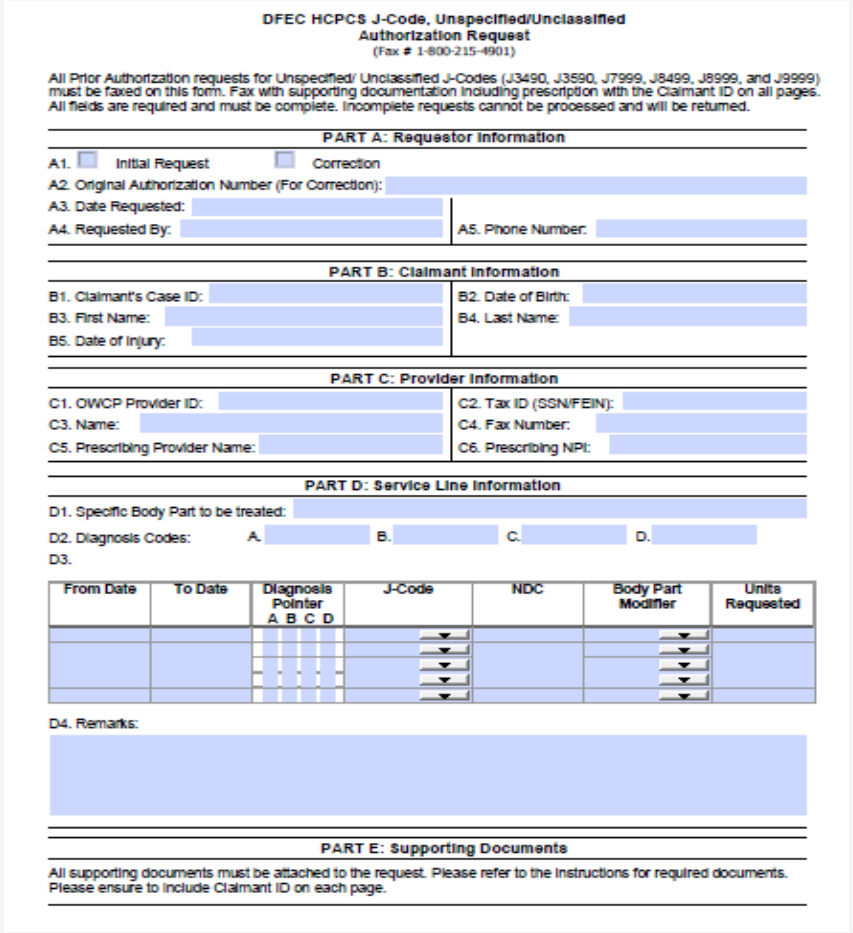
PART E: Supporting Documents

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

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.

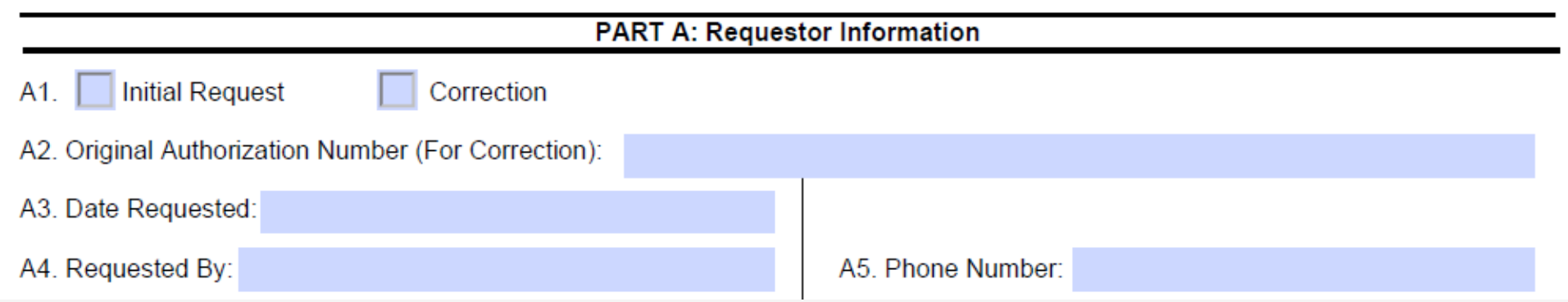
From Date	To Date	Diagnosis Pointer A B C D	J-Code	NDC	Body Part Modifier	Units Requested

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



A1. Select an option:

- Initial Request (new or first time requesting an authorization).
- Correction (to correct/add additional service lines to 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

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

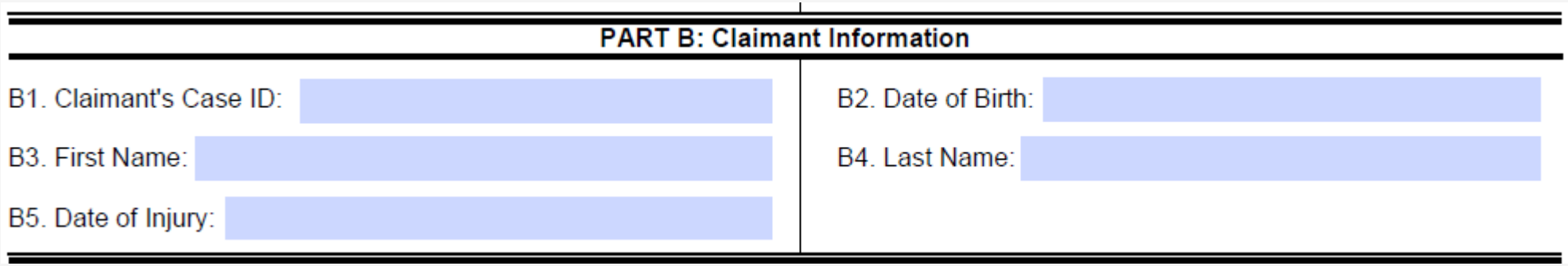
B2. Enter the Claimant's Date of Birth (mm/dd/yyyy).

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

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:

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.

Completing the HCPCS J-Code Unspecified/Unclassified Template

D1. Enter the specific body part to be treated.

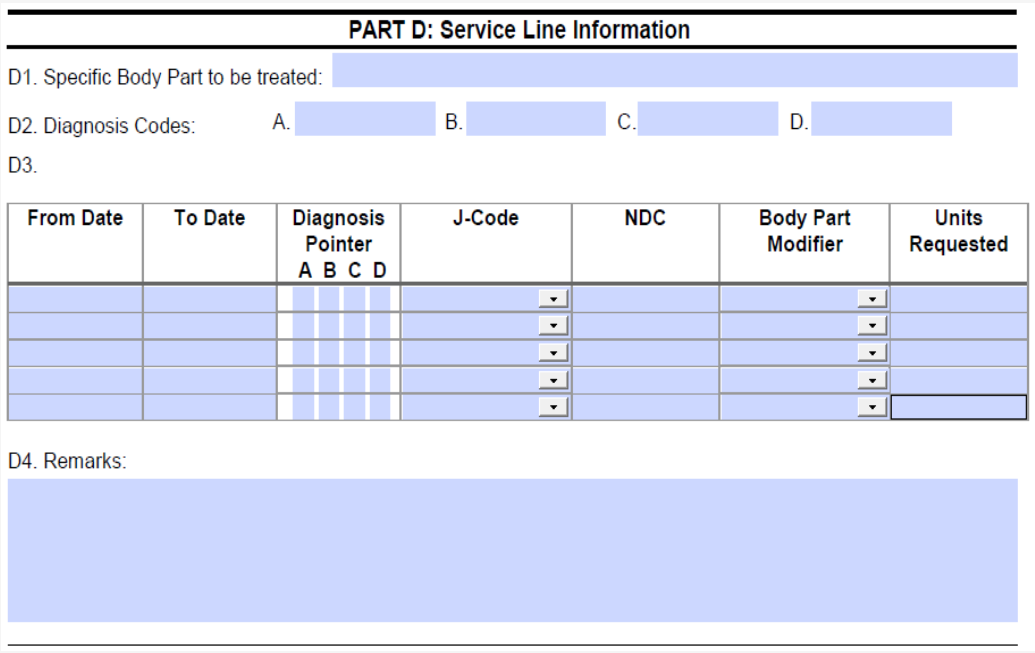
D2. Up to four ICD-9 or ICD-10 codes can be entered.

- 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). Select 50 if the equipment is for the back, neck or head area.
- Enter the number of Units requested.

D4. Enter any additional remarks.



Completing the HCPCS J-Code Unspecified/Unclassified Template

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

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

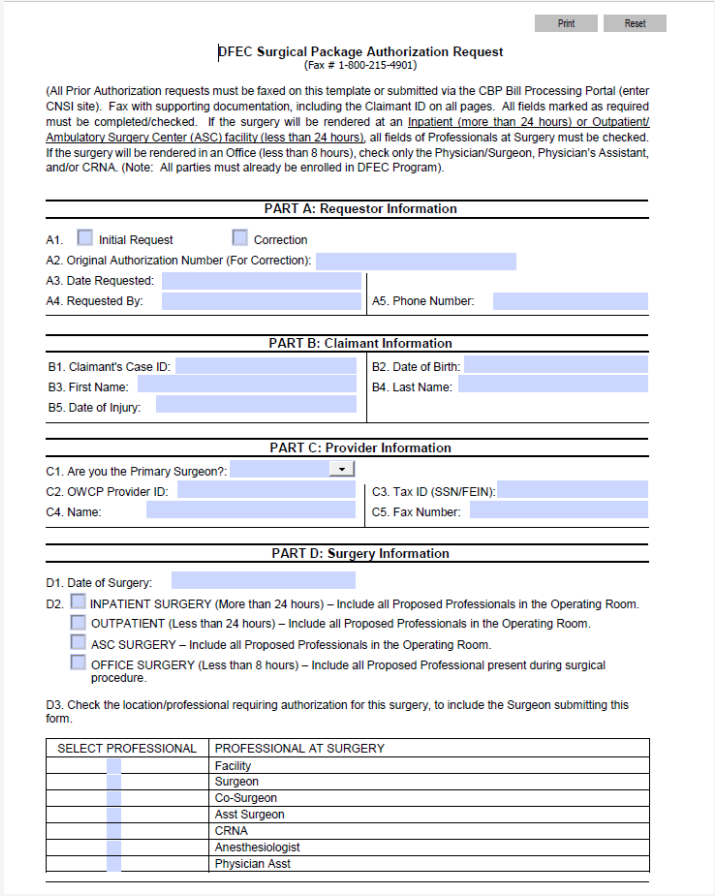
PART E: Supporting Documents

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

Requests for Surgical procedures that are level 2 or 3 services will require the completion of a Surgical Package Authorization 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 (enter CNSI site). 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 DFEC Program).

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

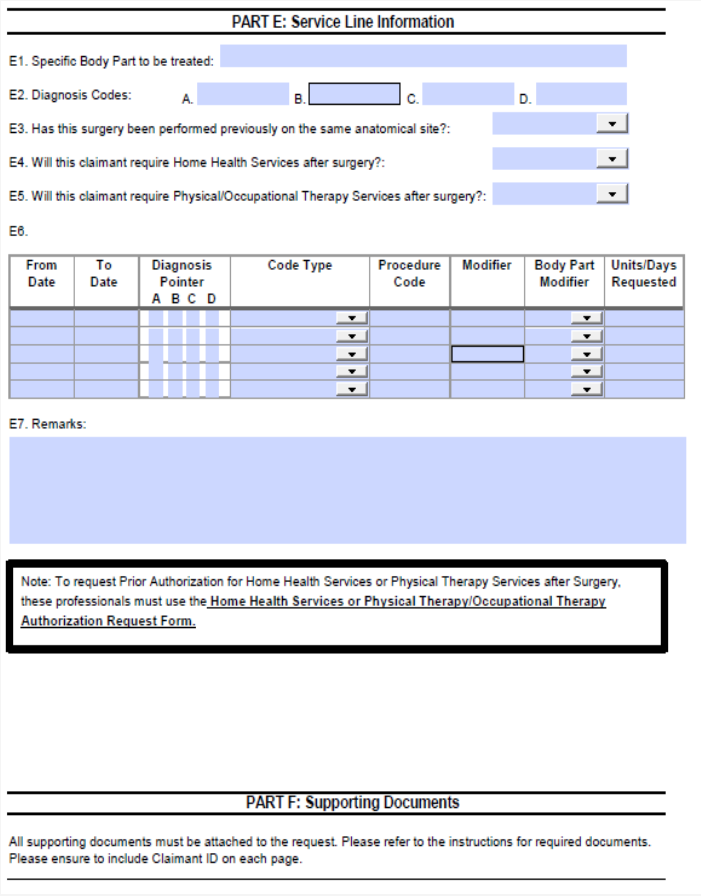
C1. Are you the Primary Surgeon?:
C2. OWCP Provider ID:
C3. Tax ID (SSN/FEIN):
C4. Name:
C5. Fax Number:

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

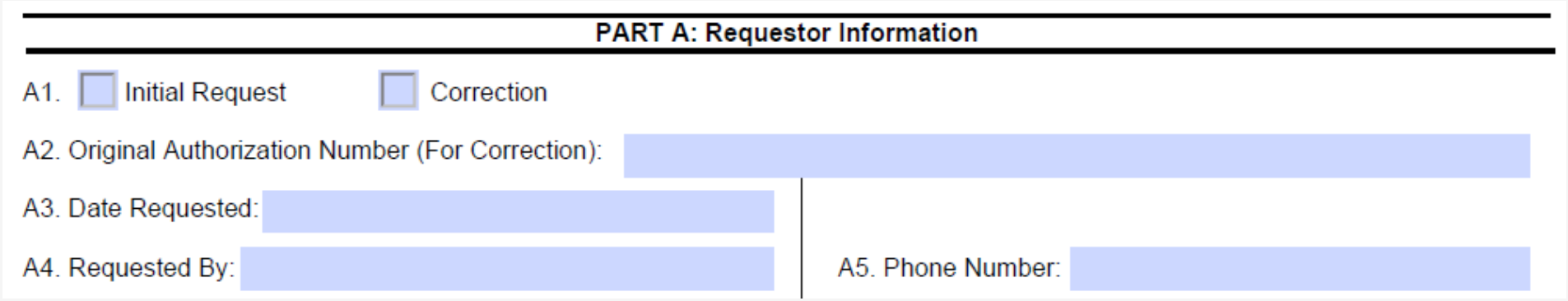
E7. Remarks:

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



PART A: Requestor Information

A1. ☐ Initial Request ☐ Correction

A2. Original Authorization Number (For Correction):

A3. Date Requested:

A4. Requested By:

A5. Phone Number:

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

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

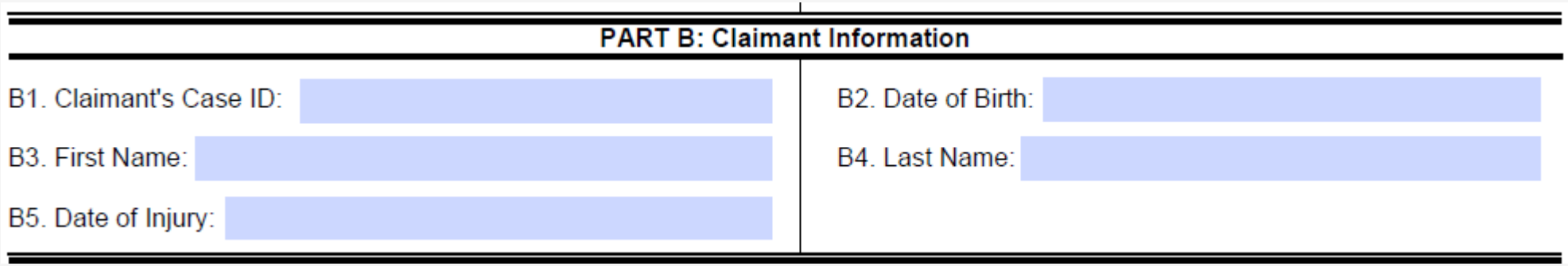
B2. Enter the Claimant's Date of Birth (mm/dd/yyyy).

B3. Enter the Claimant's First Name.

B4. Enter the Claimant's Last Name.

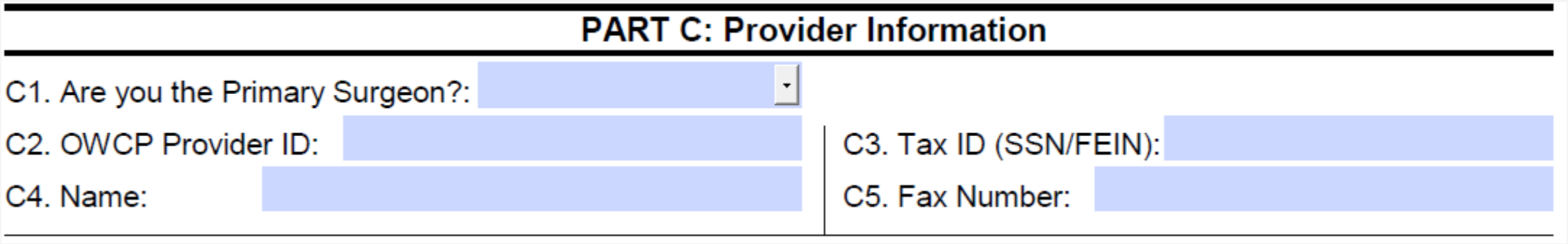
B5. Enter the Claimant's Date of Injury (mm/dd/yyyy).

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 Surgical Package Template



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

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)
- Anesthesiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Physicians Assistant (PA)

Note: One authorization will cover all professional types.

PART D: Surgery Information

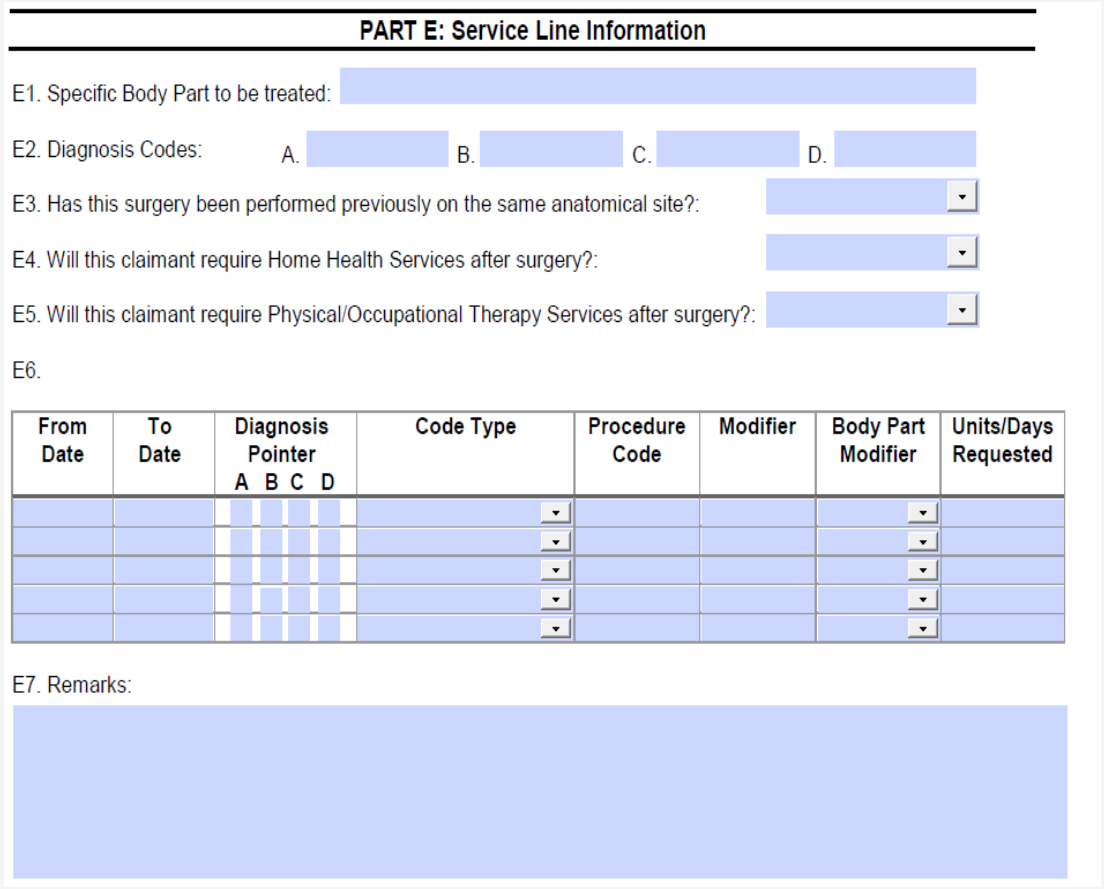
D1. Date of Surgery:

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

Completing the Surgical Package Template



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

E7. Remarks:

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.

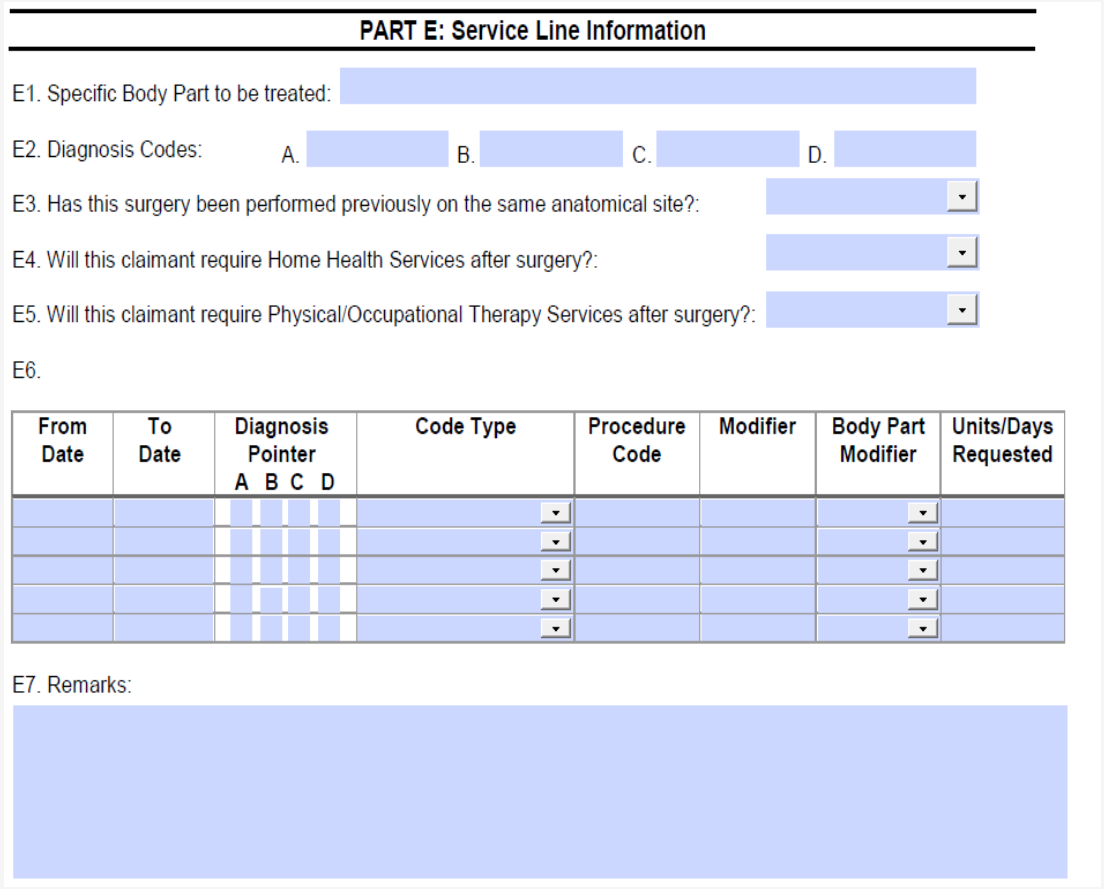
E3. Has there been a previous surgery on the body part you are treating?

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.

Completing the Surgical Package Template – Continued



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

E7. Remarks:

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/HCPCS).
- Enter the Procedure Code.
- Enter the procedure Modifier (if applicable).
- Select a Body Part Modifier option: LT(Left), RT(Right) or 50(Bilateral). Select 50 if the equipment is for the back, neck or head area.
- Enter the number of Units/Days requested.

E7. Enter any additional remarks.

Completing the Surgical Package 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.

Attach any supporting documentation needed.

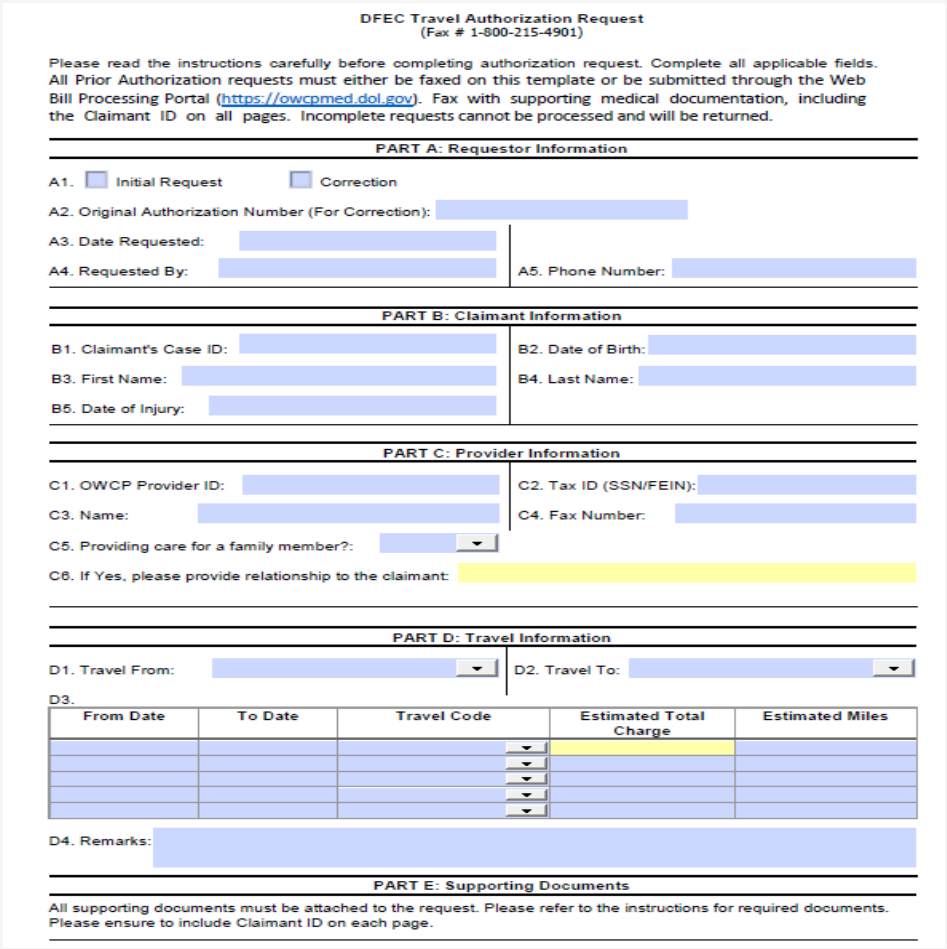
* Write the Claimant's Case ID on all additional pages submitted with the template.

Travel Template

Travel Template

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

- **A0100** - Taxi
- **A0110** - Bus, intra/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.

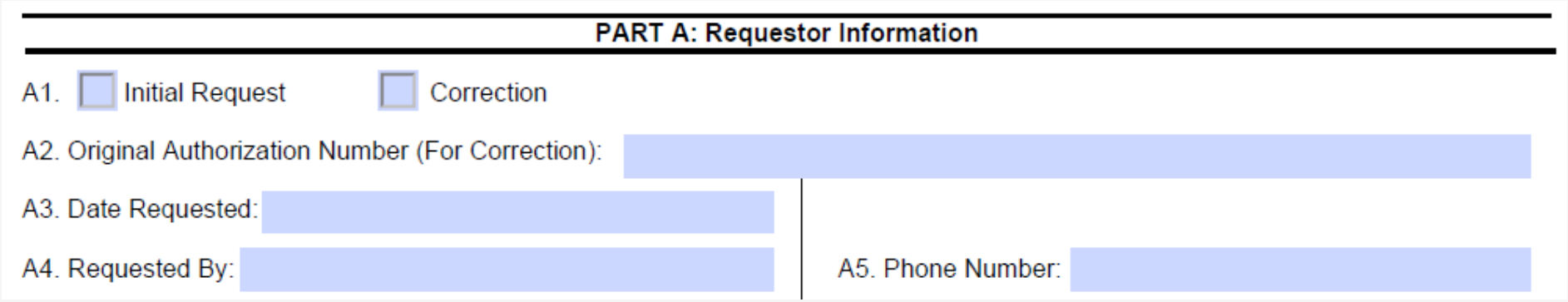
From Date	To Date	Travel Code	Estimated Total Charge	Estimated Miles

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



PART A: Requestor Information

A1. ☐ Initial Request ☐ Correction

A2. Original Authorization Number (For Correction):

A3. Date Requested:

A4. Requested By:

A5. Phone Number:

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

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

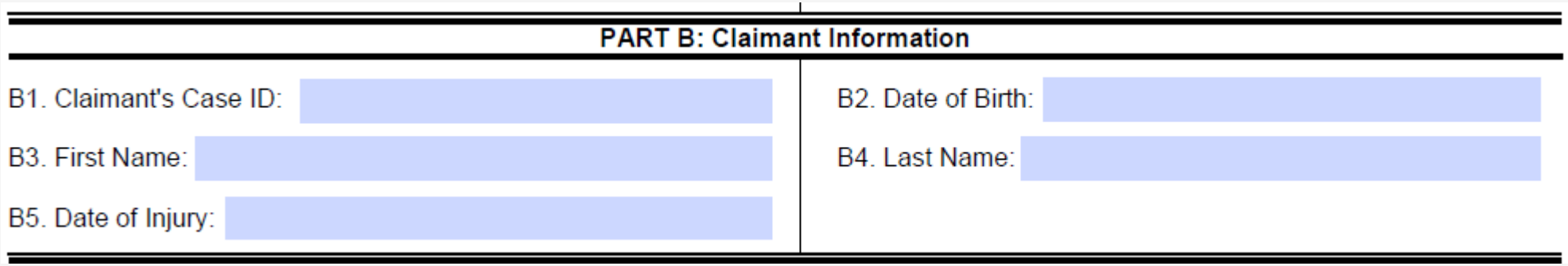
B2. Enter the Claimant's Date of Birth (mm/dd/yyyy).

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).

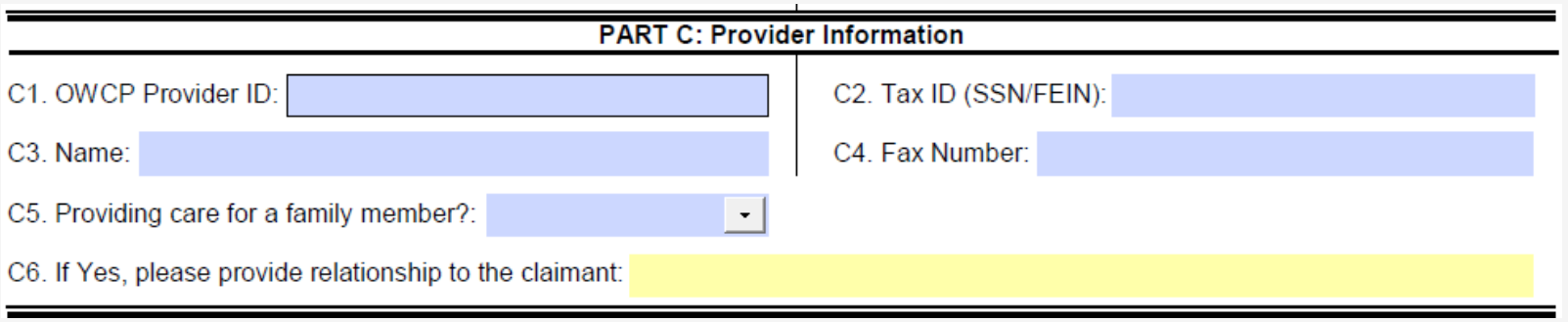
Note: All fields in Part B are required.



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 Travel Template



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 for a family member, state your relationship to the claimant. **(Only required if Yes was selected in C5)**

Completing the Travel Template

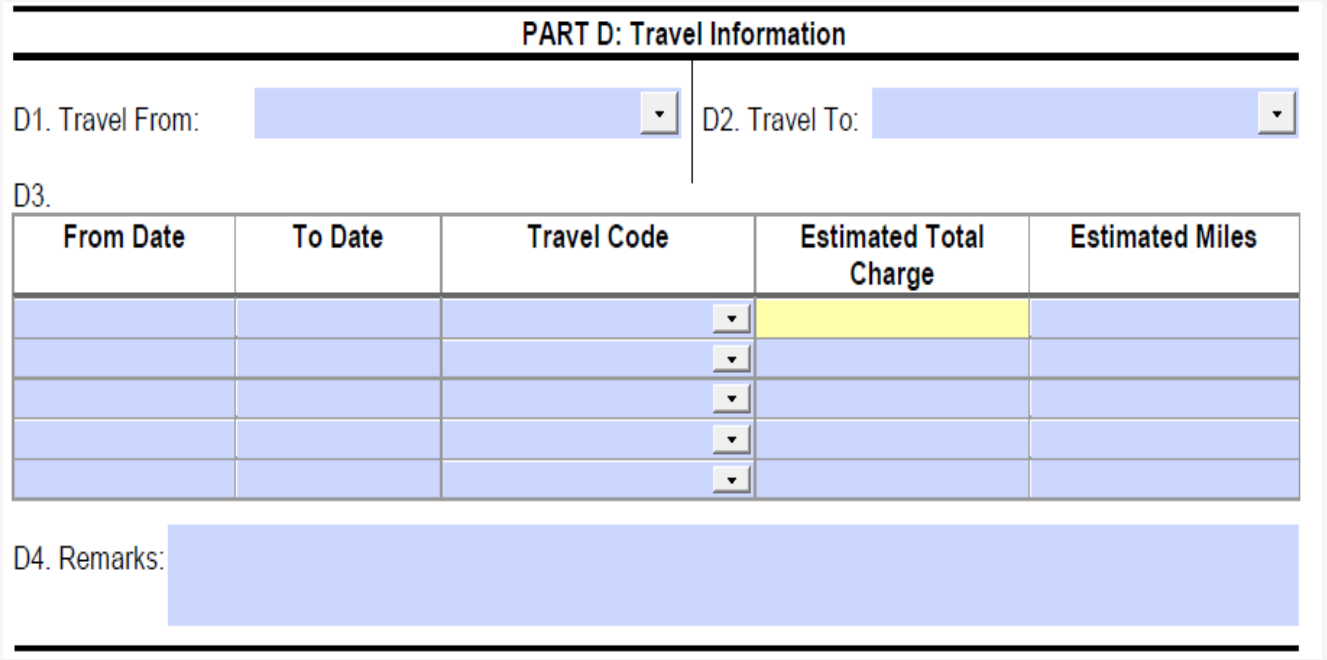
D1. Select the location where the travel started from.

D2. Select the location where the travel ended.

D3.

- Enter the travel from and to date.
- Enter the travel code(s).
- 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

Attach Receipts or Invoices to confirm the estimated total charge.

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

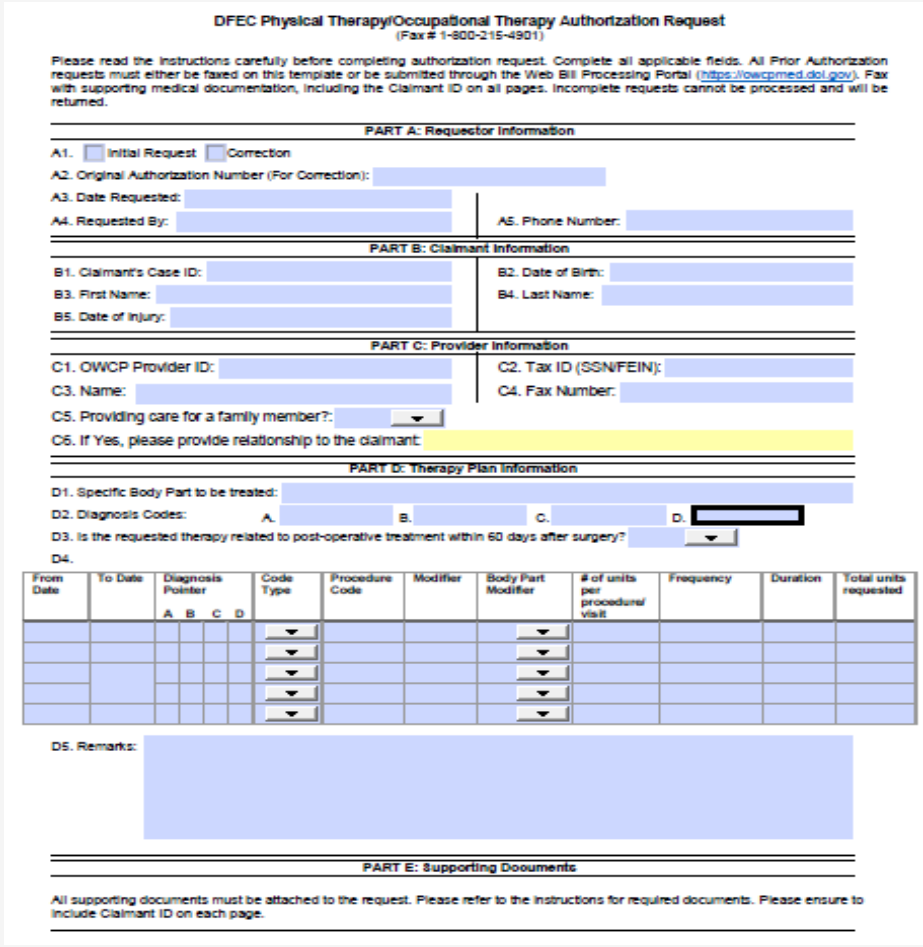
PART E: Supporting Documents

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

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.

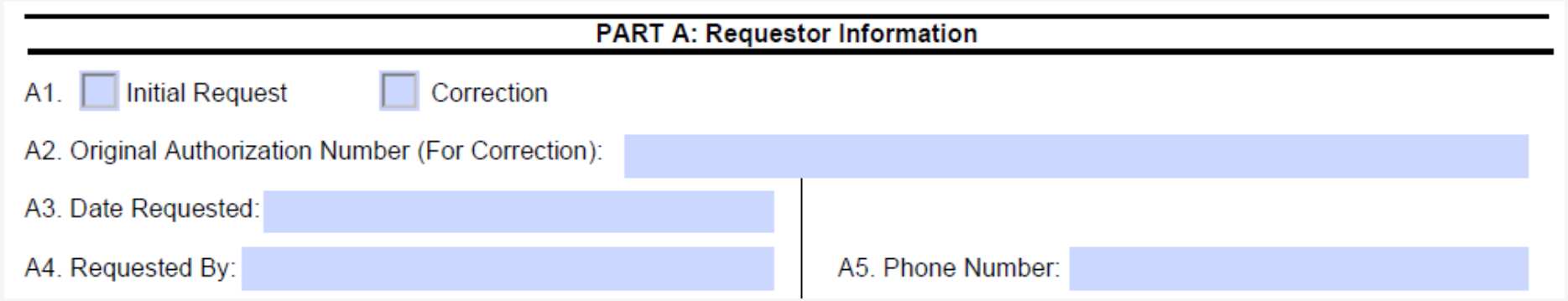
From Date	To Date	Diagnosis Pointer (A B C D)	Code Type	Procedure Code	Modifier	Body Part Modifier	# of units per procedure/ visit	Frequency	Duration	Total units requested

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


PART A: Requestor Information

A1. ☐ Initial Request ☐ Correction

A2. Original Authorization Number (For Correction):

A3. Date Requested:

A4. Requested By:

A5. Phone Number:

A1. Select an option:

- Initial Request (new or first time requesting an authorization for physical therapy/occupational therapy).
- Correction (to correct/add additional service lines to 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

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

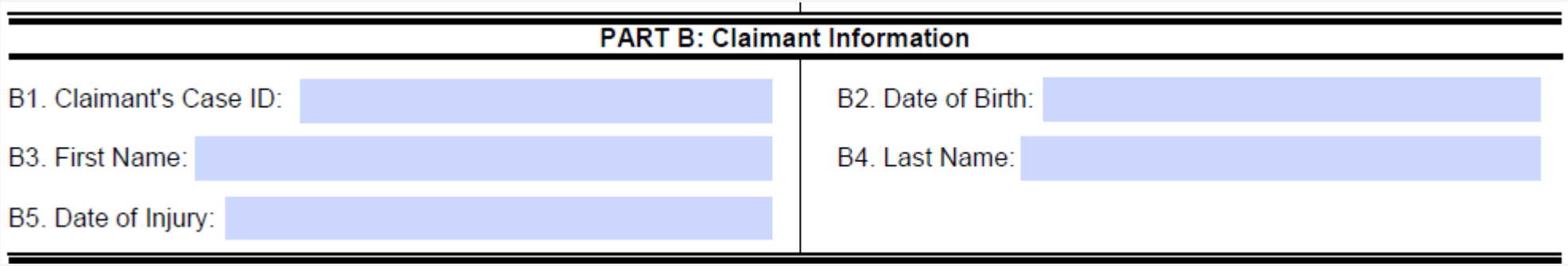
B2. Enter the Claimant's Date of Birth (mm/dd/yyyy).

B3. Enter the Claimant's First Name.

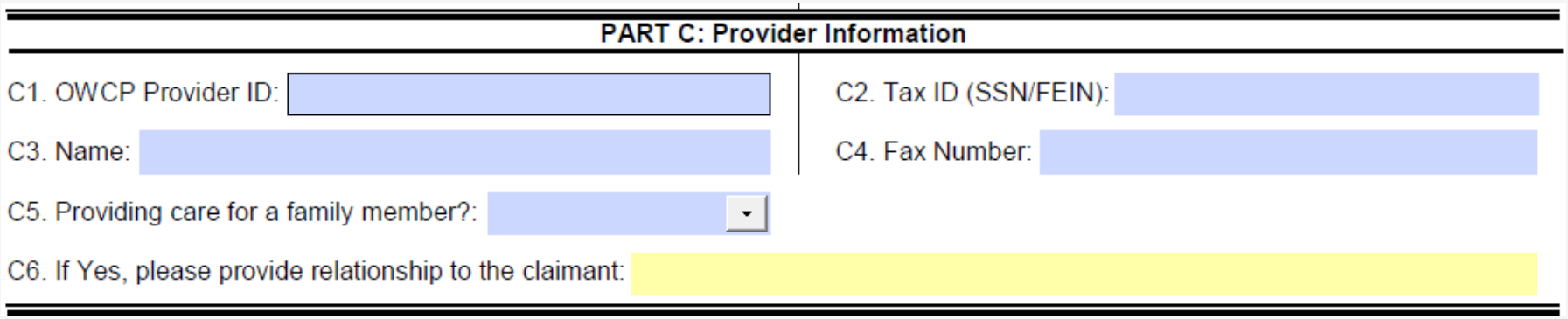
B4. Enter the Claimant's Last Name.

B5. Enter the Claimant's Date of Injury (mm/dd/yyyy).

Note: All fields in Part B are required.



Completing the Physical Therapy/Occupational Therapy Template



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 for a family member, state your relationship to the claimant. **(Only required if Yes was selected in C5.)**

Completing the Physical Therapy/Occupational Therapy Template

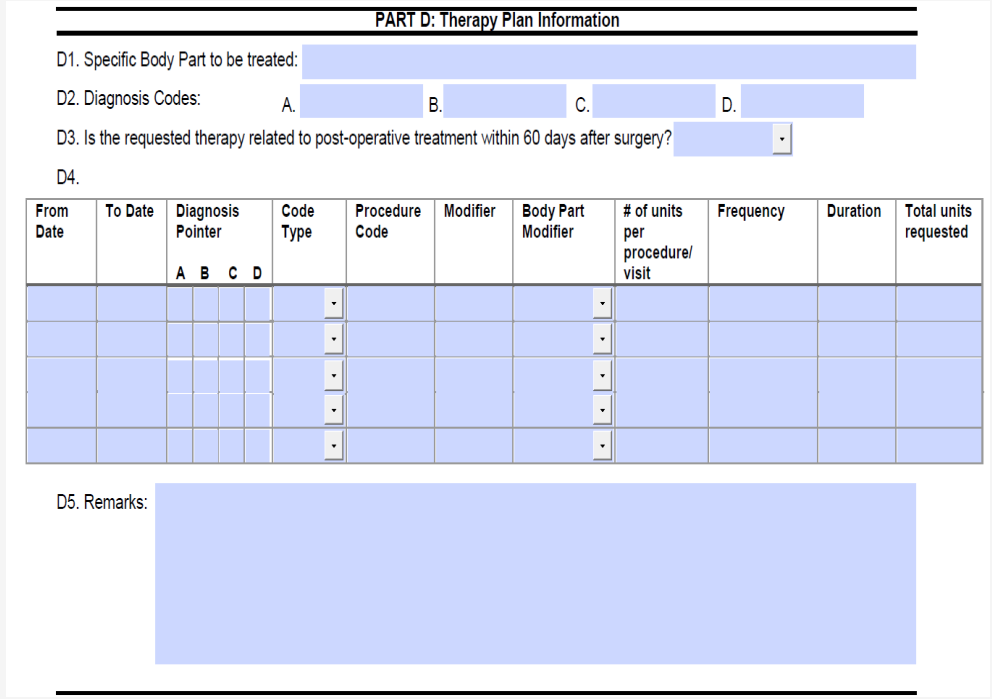
D1. Enter the specific body part to be treated.

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

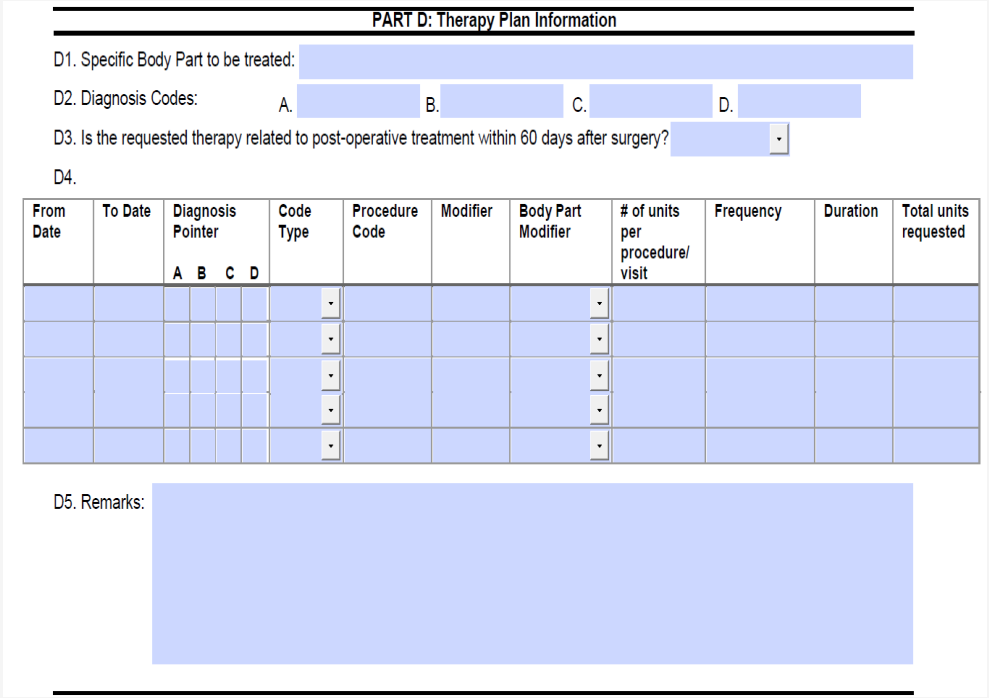
D5. Remarks:

Completing the Physical Therapy/Occupational Therapy Template – Cont.

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). Select 50 if the equipment is for the back, neck or head area.
- 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

D5. Remarks:

Completing the Physical Therapy/Occupational Therapy Template

*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 via:

- **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 on 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!