Authorization Request Form
Please fax with supporting medical documentation
800-882-6147

Effective January 3, 2005 all Prior Authorization requests must either be faxed on this template or submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal (https:\\owcpmed.dol.gov).All fields are required and must be complete.Incomplete requests cannot be processed and will be returned.

Date Requested _____ Requested by _____

Case file # _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

Conduent Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

ICD-9 Diagnosis Code(s)**(for dates of service 09/30/15 and prior)**_____

ICD-10 Diagnosis Code(s)**(for dates of service 10/01/15 and after)**_____

Procedure Code(s) and/or Modifier(s) (CPT, HCPCs,RCC)_____

_____

Specific body part to be treated_____ _____

Units/Days Requested _____

Is this a second surgery on the same body part?_____

Place of service in-home? Yes ☐ No ☐

Comments _____

Remember to send any supporting medical documentation with request.
Please put Case File # on every page faxed.