Physical Therapy, Occupational Therapy and Speech Therapy Request Form

Please fax with supporting medical documentation to 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.

☐ New Request ☐ Amended Request

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) _____

_____

Specific body part(s) to be treated _____

Frequency and Duration Requested _____

Place of service in-home? Yes ☐ No ☐

Comments _____

_____

The prescription from the attending physician and treatment plan must be attached. Please include the claimant's case file number on every page submitted.