Durable Medical Equipment
Authorization Request
Fax # 1-800-215-4901

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 documentation, including the case file number on all pages. All fields are required and must be complete. Incomplete requests cannot be processed and will be returned.

Date Requested _____ Requested by _____Phone _____

Case file # _____Claimant Name _____

Claimant Date of Birth _____ Date of Injury _____

Provider Name _____

Conduent Provider Number _____ Provider Tax ID _____

Are you in the process of enrolling? ☐ Yes ☐ No

NOTE: Up to five procedure (CPT/HCPCS) codes may be entered. (An additional form can be completed if extra space is required.)

	Date of Service		**Procedure**	**Rental or Purchase Modifier**	**Total Requested Price Per Item**
	From Date	To Date	Code	RR or NU	
1					
2					
3					
4					
5					

Treatment Plan Information:

Specific body part(s) to be treated _____

Right___ Left_____ Bilateral___

ICD-9 Diagnosis Code(s) **(Apply if date of services Prior to 09/30/2015)** _____

ICD-10 Diagnosis Code(s) **(Apply if date of services After to 10/01/2015)** _____

Duration Requested, if rental _____

Is this an implant (Y/N)_____ Total Cost of implant_____ Units Requested _____

Comments: _____

Please send prescription from attending physician and treatment plan with requests for DME.