General Medical and Surgical
Authorization Request
Fax # 1-800-215-4901

All Prior Authorization requests must be faxed on this template or submitted via the Web Bill Processing Portal (https://owcpmed.dol.gov). Fax with supporting medical 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's 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/RCC) codes may be entered. (An additional form can be completed if extra space is required.)

	Date of Service		**Procedure CPT/HCPC/RCC**		**Unit/Days Requested**
	From Date	To Date	Code	Modifier	Units or Days
1:					
2:					
3:					
4:					
5:					

Treatment Plan Information:

- Specific body part 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)** _____
- For Home health requests, frequency_____ duration_____
- Is this a second surgery on the same body part? _____
- Comments: _____