

**Durable Medical Equipment  
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 be submitted through the Medical Authorization Entry screen on the Web Bill Processing Portal(<http://owcp.dol.acs-inc.com>). **All fields are required and must be complete. Incomplete requests and requests that are not properly coded with CPT or HCPCS cannot be processed and will be returned.**

Date Requested \_\_\_\_\_ Requested by \_\_\_\_\_

Case file # \_\_\_\_\_

Claimant Name \_\_\_\_\_

Claimant Date of Birth (optional) \_\_\_\_\_

Provider Name \_\_\_\_\_

ACS Provider Number \_\_\_\_\_

Provider Tax ID \_\_\_\_\_

Date(s) of Service Requested \_\_\_\_\_

Procedure Code(s) and/or Modifier(s) (HCPCS) \_\_\_\_\_

Rental or Purchase and price per item \_\_\_\_\_

Duration Requested \_\_\_\_\_

Comments \_\_\_\_\_

**Please remember to send prescription from attending physician and/or any supporting medical documentation for request.**

**Please put Case File # on every page faxed. 800-215-4901**