

**Durable Medical Equipment
Authorization Request**
Please fax with supporting medical documentation
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 (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 _____ Phone _____

Case file # _____ Claimant Name _____

Claimant Date of Birth _____ Claimant Date of Injury _____

Provider Name _____

ACS Provider Number _____ Provider Tax ID _____

Are you in the process of enrolling? Yes No

Procedure Code Information: * Up to Five Procedure (CPT/HCPCS) codes may be entered. (For additional procedures, please complete an additional template)

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

Treatment Plan Information:

* Specific body part(s) to be treated _____

* Right____, Left____, Bilateral____, N/A____

* ICD-9 Diagnosis Code(s) _____

* Duration Requested, if rental _____

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

Comments: _____

Please remember to send prescription from attending physician and treatment plan with requests for DME. Please put Case File # on every page faxed. **Fax #800-215-4901**