Physical Therapy/Occupational Therapy
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 (owcp.dol.acs-inc.com). 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 _____

Xerox 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(s) of Service		Procedure CPT/HCPCS		# of Units (per procedure)	Fre-quency	Du-ration	Total Units Requested
	From	To	Code	Modifier				
1								
2								
3								
4								
5								

	Treatment Plan Information :		
Body part to be treated	Side of body	ICD-9 code (**Apply if date of services Prior to 09/30/2015)**	ICD-10 code **(Apply if date of services After to 10/01/2015)**

* Is the requested therapy related to post-operative treatment ? ☐ yes ☐ no

Treatment Frequency Calculation

* To calculate Total Units/Days Requested, use the following formula for each procedure code requested:
# of Units Requested (per procedure) x Frequency Requested x Duration Requested

Comments: _____

Please remember to send prescription from attending physician and treatment plan with requests for physical or occupational therapy. Please put Case File # on every page faxed.