

**Physical Therapy/Occupational Therapy
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's Name _____

Claimant Date of Birth _____ Date of injury _____

Provider Name _____

ACS Provider Number _____ Provider Tax ID _____

Are you in the process of enrolling? Yes No

Procedure Code Information: Enter up to Ten Procedure (CPT/HCPCS) codes.
For additional procedures, please complete an additional request.

	Date(s) of Service		Procedure CPT/HCPCS		# of Units per code	Frequency	Duration	Total # of Units Requested
	From	To	Code	Modifier				
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Treatment Plan Information :

Body part to be treated	Side of body	ICD-9 code

* 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 code 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. **Fax #800-215-4901**