Physical Therapy/Occupational Therapy
Authorization Request Template
Please Fax with supporting medical documentation
FAX #(800) 215-4901

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's Name ____________________

Claimant Date of Birth __________________ Claimant's DOI _________________

Provider Name ____

ACS Provider Number _____________________________________

Provider Tax ID ____

ICD-9 Diagnoses Code ___________________________

Procedure Code(s) and/or Modifier(s) (CPT, HCPCS) ______________________________

____

Specific body part to be treated _________________
Right___, Left_____, Bilateral___, N/A_____

Treatment Schedule:
Date(s) of Service Requested ________________________________
No. of units per day: ______________
No. of days of therapy per week ______________ No. of Weeks __________
Total Units Req. (no. of units per day x no. of therapy days x No of weeks = total units)
____

Treatment Plan (include long/short term goals)
____
Comments: ____

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