

**General Medical and Surgical  
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 \_\_\_\_\_

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/RCC) codes may be entered

*Note: For Units/Days Requested in the table below, please enter the number of visits anticipated for each procedure code. (For additional procedures, please complete an additional request)*

	Date of Service		Procedure CPT/HCPC/RCC		Unit/Days Requested
	From Date	To Date	Code	Modifier	Units or Days
1:					
2:					
3:					
4:					
5:					

**Treatment Plan Information:**

- Specific body part to be treated \_\_\_\_\_
- Right\_\_\_\_, Left\_\_\_\_, Bilateral\_\_\_\_, N/A\_\_\_\_\_
- ICD-9 Diagnosis Code(s) \_\_\_\_\_
- For Home health requests, frequency\_\_\_\_\_ duration\_\_\_\_\_
- Is this a second surgery on the same body part? \_\_\_\_\_
- Comments: \_\_\_\_\_

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