

# Transplant Authorization Request

## U.S. Department of Labor

Office of Workers' Compensation  
 Programs  
 Division of Energy Employees  
 Occupational  
 Illness Compensation



**Note:** Please read the instructions carefully before completing this authorization request. Complete all applicable fields. All requests with supporting documentation must either be faxed to 1-800-882-6147 or be submitted through the Web Bill Processing Portal (<https://owcpmed.dol.gov>). Please include the Claimant Case ID on all pages. Incomplete requests cannot be processed and will be returned.

OMB Control No: 1240-0NEW  
 Expiration Date: XX/XX/20XX

### PART A: Requestor Information

A1. Date Requested: [Redacted]  
 A2. Requested By: [Redacted]      A3. Phone Number: [Redacted]

### PART B: Claimant Information

B1. Claimant's Case ID: [Redacted]      B2. Date of Birth: [Redacted]  
 B3. First Name: [Redacted]      B4. Last Name: [Redacted]  
 B5. Authorized Representative: [Redacted]      B6. Phone Number: [Redacted]

### PART C: Provider Information

C1. OWCP Provider ID: [Redacted]      C2. Tax ID (SSN/FEIN): [Redacted]  
 C3. Name: [Redacted]      C4. Fax Number: [Redacted]

### PART D: Treating Physician Information

D1. Treating Physician: [Redacted]  
 D2. Treating Physician Address: [Redacted]

### PART E: Service Line Information

E1. Diagnosis Codes:      A. [Redacted]      B. [Redacted]      C. [Redacted]      D. [Redacted]

E2.

| From Date  | To Date    | Diagnosis Pointer |            |            |            | Code Type  | Procedure Code |
|------------|------------|-------------------|------------|------------|------------|------------|----------------|
|            |            | A                 | B          | C          | D          |            |                |
| [Redacted] | [Redacted] | [Redacted]        | [Redacted] | [Redacted] | [Redacted] | [Redacted] | [Redacted]     |
| [Redacted] | [Redacted] | [Redacted]        | [Redacted] | [Redacted] | [Redacted] | [Redacted] | [Redacted]     |
| [Redacted] | [Redacted] | [Redacted]        | [Redacted] | [Redacted] | [Redacted] | [Redacted] | [Redacted]     |
| [Redacted] | [Redacted] | [Redacted]        | [Redacted] | [Redacted] | [Redacted] | [Redacted] | [Redacted]     |
| [Redacted] | [Redacted] | [Redacted]        | [Redacted] | [Redacted] | [Redacted] | [Redacted] | [Redacted]     |

E3. Remarks:



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**PART F: Transplant Information**

F1. Transplant Facility: F2. Transplant Type:  
 F3. Transplant Facility Address:  
 F4. Transplant Facility Phone:  
 F5. Organ Transplant Coordinator Name: F6. Phone Number:

**PART G: Supporting Documents**

All supporting documents must be attached to the request. Failure to include supporting documentation may result in a delay in processing or denial. Please include claimant's case ID on each page. Required documentation:

- Letter of medical necessity from the treating physician describing the need for the transplant being requested. Initial and recent clinical evaluation (i.e., diagnostic studies and laboratory tests)
- A copy of the treatment protocol

**Instructions**

| <b>Part A: Requestor Information</b> |  |          |
|--------------------------------------|--|----------|
| A1.                                  | Type or print date on which this template is being completed         | Required |
| A2.                                  | Type or print name of the person requesting an authorization         | Required |
| A3.                                  | Type or print phone number of the person requesting an authorization |          |

| <b>Part B: Claimant Information</b> |  |          |
|-------------------------------------|--|----------|
| B1.                                 | Type or print claimant's case ID                       | Required |
| B2.                                 | Type or print claimant's date of birth (mm/dd/yyyy)    | Required |
| B3.                                 | Type or print claimant's first name                    | Required |
| B4.                                 | Type or print claimant's last name                     | Required |
| B5.                                 | Type or print authorized representative's name         |          |
| B6.                                 | Type or print authorized representative's phone number |          |

| <b>Part C: Provider Information</b> |   |          |
|-------------------------------------|---|----------|
| C1.                                 | Type or print service rendering provider's OWCP ID  | Required |
| C2.                                 | Type or print provider's Tax ID (SSN or FEIN)   | Required |
| C3.                                 | Type or print provider's name   | Required |
| C4.                                 | Type or print fax number. If entered, this fax number will be used for communication related to this authorization request. Leave it blank if fax number was provided during provider enrollment. |          |

| <b>Part D: Treating Physician Information</b> |   |          |
|---|---|----------|
| D1.   | Type or print referring physician's name    | Required |
| D2.   | Type or print referring physician's address | Required |

| <b>Part E: Service Line Information</b> |  |  |
|---|--|--|
| E1.                                     | Type or print ICD-09 or ICD-10 diagnosis codes for which services are being rendered, up to 4 codes are allowed. ICD-9 code is applicable if date of service is prior to 09/30/2015. Use ICD-10 code if date of service is after 10/01/2015. |  |
| E2.                                     | Service lines  |  |

|     |   |          |
|-----|---|----------|
|     | Type or print beginning date of the service   | Required |
|     | Type or print end date of the service   | Required |
|     | Select diagnosis code pointer from the diagnosis codes listed in Part D: A, B, C, D Select all applicable options.                              | Required |
|     | Select code type from following options: <ul style="list-style-type: none"> <li>• CPT Procedure Code</li> <li>• HCPCS Procedure Code</li> </ul> | Required |
|     | Type or print applicable procedure code   | Required |
| E3. | Type or print additional notes or remarks, if any   |          |

| <b>Part F: Transplant Information</b> |  |          |
|---------------------------------------|--|----------|
|                                       |  | Required |
| F1.                                   | Type or print transplant facility                              | Required |
| F2.                                   | Type or print transplant type                                  | Required |
| F3.                                   | Type or print transplant facility address                      | Required |
| F4.                                   | Type or print transplant facility phone                        | Required |
| F5.                                   | Type or print name of person coordinating the organ transplant | Required |
| F6.                                   | Type or print coordinator phone                                | Required |

| <b>Part G: Supporting Documentation</b> |   |          |
|---|---|----------|
|   |   |          |
| G1.                                     | Please check and attach the letter of medical necessity from the treating physician | Required |
| G2.                                     | Please check and attach the initial and recent clinical evaluation                  | Required |
| G3.                                     | Attach a copy of the treatment protocol   | Required |

### **PRIVACY ACT STATEMENT**

The Privacy Act of 1974, as amended (5 U.S.C. 552a) authorizes OWCP to ask you for information needed in the administration of the EEOICPA program. Authority to collect information is in 42 USC 7384d, 20 CFR 30.1 *et seq.* and E.O. 13179. The information we obtain is used to decide if the services and supplies being billed for are covered by the program and to insure that proper payment is made. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) at issue will prevent payment of the bill. Failure to supply the claim number or CPT codes will delay payment or may result in rejection of the authorization request because of incomplete information.

We are authorized to request a taxpayer identification number (TIN) or Social Security Number (SSN) under the Debt Collection Improvement Act of 1996, 31 U.S.C. 7701(c)(1), which mandates us to require persons who are doing business with a Federal agency to furnish a TIN or SSN. The SSN or TIN, and other information maintained by us may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor system DOL/OWCP-11 published in the Federal Register, Vol. 81, page 25868, April 29, 2016, or as updated and republished.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

### **PUBLIC BURDEN STATEMENT**

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1240-0NEW. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) requested will prevent payment of the bill. We estimate that it will take an average of ten minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Department of Labor, Office of Workers' Compensation Programs, Division of Energy Employees Occupational Illness Compensation, Room C3321, 200 Constitution Avenue NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**