# PHYSICIAN'S CERTIFICATION OF MEDICAL NECESSITY UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT

**U.S. Department of Labor**
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

**Instructions**

Provide the identifying information requested below, indicate the date of your face-to-face physical examination of your patient, check either the box requesting an in-home assessment or the other box indicating you are attaching a Letter of Medical Necessity, have your physician sign and date the bottom of this form and mail it to U.S. Department of Labor, OWCP/DEEOIC, P.O. Box 8306, London, KY 40742-8306. Alternatively, you may upload your completed form via the Energy Document Portal at https:// ecalaimant.do..gov. **DO NOT WRITE IN SHADED AREAS.** For additional instructions, see page 2.

OMB Control No. 1240-0002
Expiration Date: XX/XX/2024

**Patient Information**

**Name** (Last, First, Middle Initial)

**Date of Birth:** _____

**DEEOIC Case I.D.:** _____

**Address** (Street, Apt. #, P.O. Box)

**SSN: XXX-XX-** _____ (Last Four Only)

(City, State, Zip Code)

**Telephone Number(s)**

Home: ( _____

Other: (

**Treating Physician Information**

**Physician Name** (Last, First, Middle Initial)

**Telephone Number(s):**

Office: ( _____

**Address** (Name of Facility, Street, Suite #, P.O. Box)

Other: ( _____

(City, State, Zip Code)

**NOTE: The LMN cannot be signed by a nurse practioner or physician's assistant**

**National Provider Identifier:** _____

**DEEOIC Accepted Conditions**

**Date of Physician's Examination, and Request for Assessment or Letter of Medical Necessity** (check appropriate box)

**Date of Face-to-Face Physical Examination:**

☐ **In-home Assessment Requested**

Before prescribing home health care, nursing home or assisted living services for my patient, I am requesting an in-home assessment to assist me in determining the need for services related to the accepted condition(s) listed above.

☐ **Letter of Medical Necessity Attached**

I have attached a Letter of Medical Necessity that contains both a plan of care and the rationale for my conclusion that the prescribed home health care, nursing home or assisted living services are medically necessary for treatment of the accepted condition(s) listed above.

**Physician Declaration**

By signing this Form EE-17B, I acknowledge that: the above-named patient is currently under my care for the DEEOIC accepted condition(s) listed above; I have personally examined this patient on the date indicated above; I have read the DEEOIC Home Health Care Letter to Physicians; I understand that DEEOIC only pays for care that is medically necessary for treatment of DEEOIC accepted conditions; and I understand that DEEOIC cannot pay for care for any condition that may be a consequence of DEEOIC accepted condition(s) until specifically claimed for and accepted by DEEOIC. I have attached copies of the relevant medical documentation and objective testing supporting my attached Letter of Medical Necessity (if I have provided one).

_____

Physician Signature

Date

## Additional Instructions to Physician

Form EE-17B is used to obtain a Letter of Medical Necessity (LMN) from the treating physician that describes the claimant's Home Health Care (HHC) needs as they relate to one or more of the DEEOIC accepted conditions identified on this form. The LMN must state that you have personally met with and examined your patient within the past 60 days and have made a determination as to the type of care, and the frequency and duration of such in-home care, as it relates to the accepted condition(s). Medical documentation must be signed by a physician, to include, surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners. A medical evaluation from a Nurse Practioner (N.P.) or Physcian's Assistant (P.A.) should be certified by a physician.

If you feel that you need more inforation from your patient before you can prepare the LMN, you may first wish to schedule a visit with your patient to discuss his/her HHC needs. If you feel that an in-home assessment by a provider of HHC services would be of value, please check the appropriate box on page 1, sign the Physician Certification at the bottom of the form and return it to the DEEOIC Central Mail Room address below. Our claims staff will notify the HHC provider, designated by your patient, that an in-home assessment of HHC needs has been authorized by DEEOIC. Once the assessment has been completed, our district office will forward a report to your office, and you can proceed with preparing your LMN. Once you have the necessary information to prepare a LMN, here is the specific information we are seeking:

Physical Examination: DEEOIC requires a physician to have personally visited with and conducted a physical examination of the patient, within the past 60 days. Your LMN should provide a written narrative describing your physical findings at the time of examination, and the specific functional limitations resulting exclusively from the accepted work-related illness.

Type and Duration of Care: The LMN must clearly specify the type(s) of HHC required, and for each type of care must specify the number of hours per day, and number of days per week for that particular type of service. The letter must also provide a description of the specific medical services to be performed by each type of caregiver. Examples of the various types of HHC available are as follows:

Skilled Nursing Care (RN/LPN)
Home Health Aid/Personal Care Attendant
Respiration Therapist
Occupational/Physical Therapist

## Privacy Act Statement

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 USC 7384 *et seq.*) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information received will be used to determine eligibility for, and the amount of, benefits payable under EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be disclosed to physicians and other healthcare providers for use in providing treatment, performing evaluations for the Office of Workers' Compensation Programs, and for other purposes related to the medical management of the claim. (4) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue debt collection actions required or permitted by the Debt Collection Act. (5) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision.

## Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to the information collections on this form unless it displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. You are not required to respond to this collection, but failure to respond may result in an unfavorable decision. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3524, 200 Constitution Avenue N.W., Washington, D.C. 20210, and reference OMB Control No. 1240-0002 and Form EE-17B. **DO NOT SUBMIT THE COMPLETED FORM TO THIS ADDRESS.**