

**Authorization for Examination
And/Or Treatment**

U.S. Department of Labor
Office of Workers' Compensation Programs



The following request for information is required under (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No.: 1240-0046
Expires: XX-XX-XXXX

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

2. Employee's Identification (last, first, middle, SSN)

3. Date of Injury (mo. day, yr.)

4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 3, subject to the condition stated in item A, and to the condition indicated in either 1 or 2, item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

B. 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is involved, OWCP Approval for Issuing Authorization was Obtained from: (Type Name and Title of OWCP Official)

8. Signature of Authorizing Official:

9. Name and Title of Authorizing Official: (Type or print clearly)

10. Local Employing Agency Telephone Number:

11. Date (mo., day, year)

12. Send one copy of your report: (Fill in remainder of address)

13. Name and Address of Employee's Place of Employment:

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

Department of Agency

Bureau or Office

Local Address (including ZIP Code)

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Any duplication or reproduction of this form, to include via electronic means, is prohibited without the express written consent by OWCP.

PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (Last, first, middle)

15. What History or Injury or Disease Did Employee Give You?

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe) <input type="checkbox"/> Yes <input type="checkbox"/> No	16a. IDC-9 Code _____
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17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)	18. What is Your Diagnosis?	18a. IDC-9 Code _____
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19. Do You believe the Condition Found was Caused or Aggravated by the Employment activity Described? (Please explain your answer if there is doubt)
 Yes No

20. Did Injury Require Hospitalization? If yes, date of admission (mo., day, year) Date of discharge (mo., day, year) <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Is Additional Hospitalization Required? <input type="checkbox"/> Yes <input type="checkbox"/> No
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22. Surgery (If any, describe type)	23. Date Surgery Performed (mo., day, year)
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24. What (Other) Type of Treatment Did You Provide?	25. What Permanent Effects, If Any, Do You Anticipate?
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26. Date of First Examination (mo., day, year)	27. Date(s) of Treatment (mo., day, year)	28. Date of Discharge from Treatment (mo., day, year)
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29. Period of Disability (mo., day, year) (If termination date unknown, so indicate) Total Disability: From _____ To _____ Partial Disability: From _____ To _____	30. Is Employee Able to Resume <input type="checkbox"/> Light Work Date: _____ <input type="checkbox"/> Regular Work Date: _____
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31. If Employee Is Able to Resume Work, Has He/She been Advised? Yes No If Yes, Furnish Date Advised

32. If Employee is Able to Resume only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.

33. General Remarks and Recommendations for Future Care, if indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? Yes No (If yes, state specialty)

35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.	36. Address (No., Street, City, State, ZIP Code)	
	37. Tax Identification Number	39. Date of Report
	38. National Provider System Number	

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim Form" (HCFA-1500, OWCP-1500, OWCP-04 or the UB-04). Physician services must be itemized by Current Procedural Terminology Code (CPT) using current CPT-4 coding schema; or, the UB-04 and the coding schemas acceptable on this form.