## State of California Division of Workers' Compensation

# REQUEST FOR AUTHORIZATION FOR MEDICAL TREATMENT

**Section Three – Attachment to PR2** 

### **DATE OF REQUEST:**

Patient Name: Employer Name: Claim Number: Date of Injury

Requesting Provider Name addr Addr

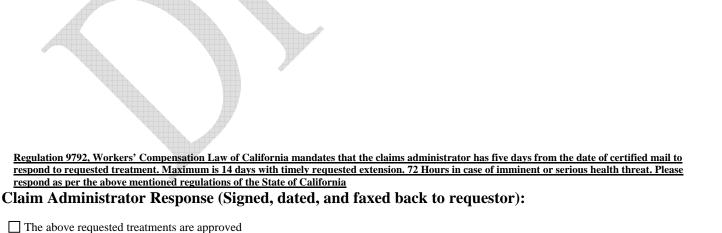
#### **Instructions:**

- 1. The PR-2 contains all the information needed to substantiate the request for medical treatment authorization such as physical examination, laboratory, imaging, or other diagnostic findings. Reference to specific guidelines used to support treatment should also be indicated in PR-2.
- 2. List Each Treatment and if applicable frequency, duration, quantity, facility etc.
- 3. If request is for surgery, please attach full surgery orders, pre-op, and post-op orders.

The treatment(s) requested are modified or denied. Please see attached response

- 4. Multiple treatment items may be requested on a single form, or individually requested on separate forms.
- 5. If request is to continue a treatment plan or therapy, please attached documentation for functional improvement

#### **REQUESTED TREATMENT(S):**



Claims Administrator Signature/Date (Fax back to provider)