



State File #: _____
Ins. Co. File # _____
Date of Injury _____

Medical Provider's Preauthorization Request

(pursuant to 21 VSA §640b) Note: Preauthorization is not required but if requested this form may be used.

Injured Worker's Information

Name: _____ Date of Birth: _____
Injured Worker's Most Recent Visit Date: _____ Work Related Injury: _____

Request for Preauthorization

The proposed medical treatment for preauthorization is:

The medical billing code(s) is: _____

Medical Support

PLEASE ATTACH TO THIS FORM AN EXPLANATION DESCRIBING THE REASON FOR THE TREATMENT, THE MEDICAL NECESSITY OF THE TREATMENT AND AN EXPLANATION OF ITS RELATION TO THE WORK INJURY.

YOU MUST ALSO INCLUDE COPIES OF RECORDS, DOCUMENTS, AND/OR OTHER MEDICAL SUPPORT AND SEND THEM TO THE INSURER PER 21 VSA §640b (DESCRIBE THE ACTUAL DATES OF RECORDS AND OTHER MATERIALS SUPPLIED TO THE INSURER IN SUPPORT OF THE PREAUTHORIZATION REQUEST)

Health Care Provider Information

Name: _____ License Number: _____
Phone Number: _____ Fax Number: _____
Address: _____

Signature of Physician/Health Care Provider Requesting Preauthorization

Transmittal Information

Date Sent to Insurer: _____ How: Mailed Faxed E-Mailed
Adjuster Name: _____ Insurer: _____
Address: _____
Phone Number: _____ Fax Number: _____
Insurer E-mail address: _____

Workers' Compensation Insurer Action (Must be made within 14 days of receiving request for preauthorization)

Date Received From Medical Provider: _____ Accepted Injury: _____
Approved Denied (attach Form 2 and supporting evidence)
IME scheduled or Records Review ordered (please note date) Date: _____

Adjuster's Signature _____ Date Signed: _____