Vermont Department of Labor
Workers' Compensation Division

Form P1(Rev. 9/16)

State File #: _____

Ins. Co. File #: _____

Date of Injury: _____

Request to Insurance Company for Preauthorization of Medical Treatment

(pursuant to 21 VSA §640b and Rule 7.0000) Note: Preauthorization is not required but if requested this form may be used.

Injured Worker's Information

Name: _____ Date of Birth: _____

Date of Most Recent Treatment: _____ Work Related Injury: _____

Request for Preauthorization

Medical Billing Code: _____ Proposed Medical Treatment: _____

_____

Extent of treatment (amount, duration and/or frequency): _____

SUPPORTING MEDICAL DOCUMENTATION MUST DESCRIBE THE REASON FOR THE TREATMENT, ITS MEDICAL NECESSITY AND AN EXPLANATION OF ITS CAUSAL RELATIONSHIP TO THE WORK INJURY.

Requesting 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: _____

Adjuster/Insurer E-mail Address: _____

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

Attach information received from medical provider and enter the date it was received: _____

The provider's request is (check one):

☐Approved ☐Denied (attach Form 2 and supporting evidence)

☐Pending IME scheduled for _____ or records review ordered on _____
and further response will be provided no later than _____ (45 days from receipt of preauthorization request).

_____ _____

Adjuster's Signature Print Adjuster's Name

_____ _____

Date Preauthorization Request Signed by Adjuster Date Response Sent

DRAFT