Vermont Department of Labor
Workers' Compensation Division

Form P1(Rev. 1/17)

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): _____

Requesting Health Care Provider Information

I HAVE ATTACHED THE SUPPORTING MEDICAL DOCUMENTATION AND MY LETTER DESCRIBING THE REASON FOR THE TREATMENT, ITS MEDICAL NECESSITY AND MY EXPLANATION OF WHY IT IS RELATED TO THE WORK INJURY.

_____

Signature of Physician/Health Care Provider Requesting Preauthorization

Name: _____ License Number: _____

Phone Number: _____ FAX Number: _____

Address: _____

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