



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

Proposed Treatment Date: _____ Should not be earlier than 14 days from date of request.

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