SPRENKLE, GEORGARIOU & DILLES , LLP, P.O. BOX 3500, SALINAS, CA 93912-3500
(831) 449-8011 phone (831) 449-2201 fax

TREATMENT/MEDICATION DENIAL FORM

PART I - TO BE COMPLETED BY CLIENT/PATIENT

1) Name of Client/Patient_____
2) Name and Address of Insurance Company
_____ Phone: ( )_____

3) Date of Injury_____ CLAIM NUMBER *_____
***claim number for date of injury medication is related to/prescribed for**

4) Designated/Prescribing Primary Treating Physician_____

5) ***Medication denied***:_____ Date Prescribed:_____

Date denied:_____ Prescribing Doctor:_____

6) ***Treatment denied***:_____ Date Prescribed: _____

Date Denied_____ Prescribing Doctor:_____

7) Name, Address and phone number of Pharmacy:_____
Name
_____( )_____
address **phone**

PART II - TO BE COMPLETED BY DOCTOR'S OFFICE STAFF

1) Do your records for this patient agree with the information set forth above? YES _____ NO_____

If "NO," what is different?_____

_____

2) Date request submitted to the insurance carrier:_____
(Please attach a copy of the request. If faxed, please attach a copy with the fax transmission date stamp.)

3) Did you request authorization for medical treatment using
DWC Form RFA "Request for Authoriation for Medical Treatment"? YES _____ NO_____
If "NO" please resubmit request using DWC Form RFA
Please attach a copy of any written denial.

Date of denial_____ Denial was made by: TELEPHONE E-MAIL FAX LETTER
circle one

Name of Individual_____
Name of Company _____

What reason was given for the denial?_____

4) Has the doctor appealed the denial? YES_____ NO_____. If yes, date of appeal:_____

Please attach a copy of any written appeals.

_____ _____

DATE: DOCTOR'S STAFF MEMBER'S NAME **please print**