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TREATMENT DENIAL FORM

PART I - TO BE COMPLETED BY CLIENT/PATIENT

1) Name of Client/Patient_____ DOB:_____

2) Name and Address of Insurance Company_____

_____( )_____
phone

3) **Date of Injury***_____
*** date of injury treatment is related to/prescribed for**

4) **Claim Number***_____
*** claim number for date of injury treatment is related to/prescribed for**

5) Designated Primary Treating Physician_____

6) Treatment denied:_____

Prescribing Doctor:_____

Date Prescribed: _____ Date Denied_____

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**