AUTHORIZATION REQUEST FOR ADDITIONAL PHYSICAL THERAPY TREATMENT

PLEASE TYPE OR PRINT AND PROVIDE ALL OF THE INFORMATION REQUESTED

Claim Number

REQUEST FOR ADDITIONAL PHYSICAL THERAPY TREATMENT

Name of Injured Employee | SSN# | Date of Injury

Name of Employer | Name of Treating Physician

Date of Last Treatment | Number of Treatments Since Injured's First Visit

DESCRIBE THE PRESENT CONDITION OF THE INJURED EMPLOYEE (Include Your Objective Findings, Symptoms, and Patient Complaints)

DEFINE AND GIVE THE NUMBER OF ADDITIONAL TREATMENTS FOR WHICH AUTHORIZATION IS REQUESTED:

Give the Date By Which the Treatment Will Be Completed If Authorization is Granted:

MUST PROVIDE NEW PRESCRIPTION WITH EACH ADDITIONAL TREATMENT REQUEST

Date | Signature and Address of Physical Therapist | Telephone Number

P.T.

FOR INSURER'S ACTION

[ ] AUTHORIZATION IS GRANTED FOR ADDITIONAL P.T. TREATMENTS

[ ] Authorization for Additional Physical Therapy Treatment is **Denied**. Treating Physician Will Be Consulted in this case.

[ ] Other Action:

Date | Signature | Title