REHABILITATION PROVIDER'S REQUESTION FOR ADDITIONAL AUTHORIZATION FOR TREATMENT

SHOULD BE FORWARDED TO INSURER/SELF-INSURED EMPLOYER WITH MOST RECENT REASSESSMENT ATTACHED:

EMPLOYEE INFORMATION:

Social Security No.: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

EMPLOYER INFORMATION:

FEIN: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

INSURANCE CARRIER: _____

IF THE IDENTITY OF THE INSURER IS UNKNOWN, CONTACT THE DIVISION OF WORKERS' COMPENSATION AT (401) 462-8116 FOR THE INFORMATION.

EMPLOYEE'S INJURY INFORMATION:

Injury Date: _____

Incapacity Date: _____

DIAGNOSIS: _____ ICD 9 Code: _____
DIAGNOSIS: _____ ICD 9 Code: _____
DIAGNOSIS: _____ ICD 9 Code: _____

1. TREATMENT TO DATE
   a. Date of initial evaluation: _____
   b. Total # of visits to date: _____
   c. Description of treatment to date, including modalities: _____
   d. Present objective findings (including functional ability): _____
2. FUTURE TREATMENT
   a. Rationale and goals for continuation of treatment: _____
   b. Restated or revised treatment plan: _____
   c. What functional activities/work-related skills is the client now able to perform? With how much assistance:
3. a. Number of additional treatments requested: _____
   b. Frequency: _____

_____ _____ _____
Therapist Completing Reassessment Lic. # Date of Evaluation

FOR INSURER'S USE ONLY

Date Rec'd	Rec'd By	Approval	Denial	# of Approved Treatments	Case Manager

THIS FORM IS TO BE RETURNED WITHIN 10 DAYS TO THE TREATMENT PROVIDER.

MAB06 (8/05) RI Workers' Compensation Court Medical Advisory Board