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(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

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 Authorization 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 form completed: _____ Completed by: _____
DOCTOR'S STAFF MEMBER'S NAME please print