State File #: _____

Ins. Co. File #: _____

Date of Injury: _____

MEDICAL EVIDENCE FOR PRE-AUTHORIZATION REQUEST

1. Explain the reason and medical necessity for the proposed treatment (attach additional pages if needed):

2. Explain how the proposed treatment is related to the patient's work injury (attach additional pages if needed):

_____ _____

Signature of Physician/Health Care Provider Date

_____ _____

Name of Physician/Health Care Provider Practice Name