Ohio | Bureau of Workers' Compensation

Request for Additional Medical Documentation for C-9

Provider name	Provider fax number	Date mailed/faxed
Injured worker name	Claim number	Date C-9 received

We have received the request for treatment form C-9, dated _____. Unfortunately, we cannot complete your request.

We require medical documentation before we can determine your request. Please submit the documentation checked below and return it within 10 business days to allow for a treatment decision. **Failure to submit requested medical documentation may result in dismissal of the treatment request.**

Reports

☐ Office/Progress notes _____

☐ Operative report _____

☐ Consult/second opinion _____

☐ Path/Lab _____

☐ Therapy (PT/OT/CMT/OMT) _____

☐ Psychiatric treatment summary _____

☐ Provide a brief narrative to explain the need for further passive therapy, including the functional benefits derived from this treatment plan. Include information concerning long-term plans for this patient, including initiation of an active exercise program and return to work status.

_____

_____.

☐ Provide a brief narrative regarding the causal relationship between the current complaints and the injury.

_____

_____.

Interpretations

☐ Radiology _____

☐ NCV / EMG _____

☐ EKG _____

☐ MRI _____

☐ CT Scan _____

Information concerning requested services/supplies

☐ CPT / HCPCS codes _____

☐ Site of services _____

Hospital

☐ Admission history and physical _____

☐ Discharge summary _____

☐ Discharge plan-inpatient _____

☐ Emergency dept. report _____

Other

_____

_____

Please return the requested documentation to the attention of:

MCO name (print, type or stamp)	Fax number ( )	Telephone number
Address	City/State	ZIP code