Bureau of Workers' Compensation

Request for Additional Medical Documentation for C-9 Psychological Services

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

Please return the requested documented to the attention of:

MCO name (print, type or stamp)	Fax number ( )	Telephone number

We received the *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9), dated_____. However, we require additional 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.**

Please provide the items checked below.

☐ Duration of each previously authorized treatment was _____ minutes. If the anticipated duration of treatment will change with this C9, please explain._____

_____

☐ Has the injured worker missed any counseling/psychotherapy sessions in the last six months? If yes, please specify the total number, dates and reason, if known._____

_____

☐ Medication prescription and monitoring (List prescribed medications, prescriber's name and frequency of medication-management visits.):_____

_____

☐ Have there been recent medication changes? ☐ No ☐Yes, please note the changes._____

_____

☐ Document medication side effects reported/observed and compliance with current medications._____

_____

☐ Results of psychological testing approved on:_____

☐ Treatment plan (Include symptoms, assessment, plan, frequency of psychotherapy treatment and rationale, progress to date, and how the allowed psychiatric conditions are affecting the injured worker's ability to function (ADL's, etc.)._____

_____

_____

☐ Information on long-term plan for the injured worker, including initiation of self-coping skills and mechanisms:

_____

_____

☐ Return-to-work barriers for the injured worker and the plan to address barriers:_____

_____

_____

Mental health provider name (please print or type)	
Mental health provider's signature	Date