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**

BWC-1112 (Rev. 3/12/2011)

C-9-A