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