

**(DENIAL OF REQUEST FOR AUTHORIZATION)**

BWC LOGO

(Project Use Only - Corr6)

mm/dd/yy

ADDRESSED TO:  
(Provider)

Injured Worker:  
Claim Number:  
Injury Date:  
Claim Type:

Employer Name:  
Policy Number:  
Employer Status:  
MCO Name:  
MCO Number:

We have received your request dated mm/dd/yy for:

(INSERT - description of original request)

Your request for authorization is denied for the following reasons:

(INSERTS)

Should the injured worker or employer or their representative disagree with this decision, they may file a motion (C-86) with BWC. Any new evidence they wish to have considered must be included with the motion. The evidence BWC considered in making this decision is available upon request.

If you have any questions regarding this authorization denial, contact the assigned team at the telephone number listed below.

Claims Rep:  
(Service Office Name)  
(Service Office Address)  
(Service Office City/St)

Team #:  
Phone #:  
Fax #: