(AUTHORIZATION APPROVAL)

BWC LOGO

(Project Use Only - Corr5)

mm/dd/yy

ADDRESSED TO:
(Physician of Record)

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 approved as follows:

Code/Auth Number	Start Date	End Date	Number of Units

(INSERT - Reason for modification, if needed)

The prior authorization number should be listed in the appropriate box on the billing form as instructed in your Provider Billing and Reimbursement Manual.

The services authorized must be initiated within 60 days of this notification or within the time frame indicated above, whichever is sooner. Progress notes or reports must be submitted after each service is rendered. Reimbursement is subject to the maximum allowable payment.

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 approval, please contact the assigned team member at the telephone number listed below.

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

Team #:
Phone #:
Fax #: