**TREATMENT AUTHORIZE/DENY**

Dear \_\_\_\_\_\_\_\_\_\_\_\_,

**Your Treatment.**

This notice is about your treatment recommendations.

We have a request for treatment authorization. The requested treatment is {Drop down: **authorized or denied**}

**{Drop Down between Treatment Authorized and Treatment Denied}**

**Treatment(s) authorized:**

* The medical information in the claim file supports the requested treatment of <enter treatment> and is authorized under the claim. The authorized procedure code(s) are: <enter procedure codes>.

**Free Text Box:** Extra information (ie. 12 physical therapy for 60 days, surgery authorization is authorized for 60 days, etc.

**Treatment Denied:**

* The request for <enter treatment request> is denied. <Drop Down-Further investigation is needed>.

**Free Text Box:** Extra information as to the reason for the denial (ie. 12 physical therapy has been performed under the claim without gain, surgery authorization does not meet guidelines, further investigation is needed. etc.

**Contact me if questions.**

If you have questions about the action being taken, or have additional information you’d like to provide related to this action, please contact me at the phone number below. I’d be glad to discuss further and answer any questions you may have. If after we discuss, you still have concerns, you may send a dispute to the Department of Labor and Industries. All disputes must be in writing at the address listed below.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim Adjudicator Date Phone