*North Carolina Industrial Commission*

IC File #_____

Date of Injury_____

# *REQUEST FOR PREAUTHORIZATION OF MEDICAL TREATMENT*

**The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act.**

| | | | |
|---|---|---|---|
| Employee's Name | | Requesting Provider | ( ) Telephone Number |
| Address | | Provider Billing Address | City State Zip |
| City | State Zip | Tax ID | |
| ( ) Home Telephone | ( ) Work Telephone | Form Prepared By | |
| XXX-XX- Last 4 digits of SSN | ☐ M ☐ F Sex / / Date of Birth | ( ) Telephone Number | Email Address |

1. The health care provider above requests preauthorization for the following surgery or inpatient admission and all pertinent clinical documentation regarding this request is attached.

Diagnosis: _____ Facility/Place of Service: _____

Setting: _____ Address: _____

Outpatient or Inpatient Phone & Fax: _____/_____

Diagnosis Code ICD-9:: _____ Tax ID: _____

Principal CPT Code: _____ Billing Contact: _____

2. Requested Service (include description, including body part(s)):

_____

_____

_____

_____

3. Frequency and Date(s) of Service (include date or length of service and admission date for inpatient treatment):

_____

_____

4. To be completed by Insurer: Procedure/Admission is ☐ Authorized.(or) ☐ Denied upon initial review. (Attach any explanation for decision or state additional information needed.) Insurer determinations shall be sent to all interested medical providers.

Date Completed: _____ Company Name: _____

Signed By: _____ Official Title: _____

Print Name: _____ Preauthorization Number: _____

This form shall be transmitted by the health care provider to the insurer at the e-mail address or fax number designated in the insurer's preauthorization review policy:

***CLAIMS ADJUSTER OR DESIGNATED PREAUTHORIZATION AGENT:*** _____

***FAX NUMBER:*** _____

***EMAIL:*** _____



**Form 25PR (Provisional)**

IC File #_____

Date of Injury_____

Employee Name_____

# *REQUEST FOR PREAUTHORIZATION OF MEDICAL TREATMENT (CONTINUED)*

**PROVIDER TO COMPLETE THIS PAGE TO APPEAL INITIAL DENIAL OF REQUEST.**

| | |
|---|---|
| Review Professional | Requesting Provider ( ) Telephone Number |
| Address | Provider Billing Address City State Zip |
| City State Zip | Tax ID |
| Email Address ( ) Telephone | Form Prepared By |
| | ( ) Telephone Number Email Address |

1. Professional Qualifications and Areas of Specialty and State(s) of Licensure of Review Professional:

2. Review Findings and Determination (G.S. 97-25.3(a)(4)):

3. Procedure is ☐ Authorized (or) ☐ Denied. (Complete 2 above and attach any further explanation for decision or state additional information needed.) Insurer determinations shall be sent to all interested medical providers.

Date Completed: _____

Signed By: _____

Print Name: _____

Peer To Peer Conducted? ☐ **YES** ☐ **NO**

Date: _____

Precertification Number _____

This form shall be transmitted by the health care provider to the insurer at the e-mail address or fax number designated in the insurer's preauthorization review policy:

***CLAIMS ADJUSTER OR DESIGNATED PREAUTHORIZATION AGENT:*** _____

***FAX NUMBER:*** _____

***EMAIL:*** _____



**Form 25PR (Provisional)**