



Physical Medicine Authorization Request

Return completed form to:
BrickStreet Mutual Insurance
P.O. Box 3151
Charleston, WV 25332-3151

FORM CAN BE COMPLETED BY PHYSICAL THERAPIST WITH TREATING PHYSICIAN'S SIGNATURE

Claimant Name:	Date of this evaluation:
Claim Number:	
Claimant SSN:	Number of physical medicine treatment visits to date:
Date of Injury:	
Physician's Name and Address:	Physician's Phone Number:
Vendor Number:	

Authorization is requested for the following treatment plan

Modality / CPT Code	Frequency	Duration

Other treatment, diagnostic tests, medications or referrals requested:

Is the claimant currently working?

What other types of treatment is this patient currently undergoing?

List all treating diagnosis (Indicate if a new diagnosis needs to be added to the claim)

What are your objective findings?

Additional comments to provide justification for authorization. (Attach additional documentation if needed)

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware that the law, specifically § 61-3-24g, provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge my contractual obligations to BrickStreet Insurance and agree to release any office notes and test results immediately to BrickStreet Insurance.

Physician Signature: _____ Date: / /