State of California

Division of Workers’ Compensation

­­\_\_\_\_Request for Authorization Additional pages attached

**RFA &PRIMARY TREATING PHYSICIAN’S PROGRESS REPORT (PR-2R)**

Check the boxes which indicate why you are submitting a report at this time. If the patient is “Permanent and Stationary”

(i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

* Periodic Report (required 45 days after last report) Change in treatment plan Released from care
* Change in work status Need for referral or consultation Response to request for information
* Change in patient’s condition Need for surgery or hospitalization

Other:

**Patient:**

Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex \_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation SS # \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ Phone (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Claims Administrator:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer name:** Employer Phone ( )

The information below must be provided. You ~~may~~must use this form and append additional pages if more space is needed.~~or you may substitute or append a narrative report~~.

**Subjective complaints:** Review of prior treatment outcomes(Include treatment rendered since last report; **changes** in treatment plan & results)

**Objective findings**: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

**Diagnoses:**

1. ICD-9 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. ICD-9 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. ICD-9 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­\_\_\_\_\_\_\_Request for Authorization

\_­­\_\_\_\_\_**Check box if the patient faces an imminent and serious threat to his or her health.**

**\_\_\_\_\_\_\_Check box if request is written confirmation of a prior oral request.**

**Discussion of potential future treatment options**

**Treatment Requested on this date :** List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider**.** Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). **Use of CPT codes is encouraged**.

\_\_Authorized or To UR \_\_\_ Signature Date

1. PT freq duration
2. Drugs name dose frequency

\_\_Authorized or To UR\_\_\_\_ Signature Date

\_\_Authorized or To UR \_\_\_ Signature Date

1. ICD-Code­­­ Procedure requested frequency f­­

\_\_Authorized or To UR \_\_\_ Signature Date

1. ICD-Code­­­ Procedure requested frequency

\_\_Authorized or To UR \_\_\_ Signature Date

1. ICD-Code­­­ Procedure requested frequency

**Work Status:** This patient has been instructed to:

\_\_Remain off-work until\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_Return to *modified* work on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with the following limitations or restrictions

(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

\_\_\_Return to full duty on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_with no limitations or restrictions.

**Primary Treating Physician: (**original signature, do not stamp) Date of exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cal. Lic. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NPI \_\_\_\_\_\_\_

Executed at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX\_\_\_\_\_\_\_\_\_\_\_\_