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**.

1. PT freq _____duration _____

__Authorized or To UR ___
Signature Date

2. Drugs name_____dose_____frequency_____

__Authorized or To UR____
Signature Date

3. ICD-Code_____Procedure requested_____frequency_____

__Authorized or To UR ___
Signature Date

4. ICD-Code_____Procedure requested_____frequency_____

__Authorized or To UR ___
Signature Date

5. ICD-Code_____Procedure requested_____frequency_____

__Authorized or To UR ___
Signature Date

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_____