COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Notification by an Authorized Treating Provider

NOTIFICATION IS FOR TREATMENT CONSISTENT WITH THE MEDICAL TREATMENT GUIDELINES

Please fill out all required information, as missing information may delay your request

Date of Injury | **Patient's DOB** | **Carrier Claim #** | **Date Sent**

Patient's Name: Last | First | M.I.

Insurance Carrier's/Agent's Name

Address: Number and Street | City | State | Zip Code

AUTHORIZED TREATING PROVIDER SUBMITTING NOTIFICATION

Provider's Name | Phone # | Fax # OR Email | NPI/FEIN

Address: Number and Street | City | State | Zip Code

CERTIFICATION THE PRESCRIBED TREATMENT IS WITHIN THE MEDICAL TREATMENT GUIDELINES

Specify treatment/service(s) and billing code(s) | Dx/ICD-10 Code

Identification of the specific Medical Treatment Guideline applicable to the prescribed treatment/service (Rule 17):

Guideline | Section

☐ Supporting documentation attached

I certify that the prescribed treatment is medically necessary and within the Medical Treatment Guidelines.

ATP's Signature | Date

TO BE COMPLETED BY THE CARRIER. Per Rule 16 the self-insured employer or employer's insurance carrier shall respond with their required information (noted in the gray shaded areas) within five (5) business days from receipt of the provider's notification.

Date Received: _____

☐ Form is incomplete

☐ Notification Confirmed; Authorization # _____

☐ Notification Denied for the following reason(s):

- ☐ No admission of liability or final order finding the injury compensable has been issued (for reported claims).
- ☐ Proposed treatment is not related to the admitted injury.
- ☐ Provider submitting Notification is not an ATP or is proposing for treatment to be performed by a non-eligible ATP.
- ☐ Injured worker is not entitled to proposed treatment pursuant to statute or settlement.
- ☐ Medical records contain conflicting opinions among the ATPs regarding proposed treatment.
- ☐ The prescribed treatment falls outside of the Medical Treatment Guidelines and will be reviewed as a Prior Authorization. (additional information requested)

I certify that copies of the confirmation/denial were completed and sent to the health care provider on the date below:

By (Print Name) | Signature | Title | Date