LWC FORM 1010A - FIRST REQUEST

PLEASE PRINT OR TYPE

SECTION 1. IDENTIFYING INFORMATION			
PATIENT	Last Name: First: Middle:	Social Security Number:	
	Employers Name:	Claim Number (if known):	

SECTION 2. CARRIER/SELF INSURED EMPLOYER'S FIRST REQUEST FOR REQUIRED MINIMUM INFORMATION

CARRIER

I have received a request for authorization for the above referenced matter and have determined it lacks the required minimum information of 40:2715(C) - Please check all that apply

- ☐ History provided to the level of condition and as provided by Medical Treatment Schedule
- ☐ Physical Findings/Clinical Tests
- ☐ Documented functional improvements from prior treatment
- ☐ Test/imaging results
- ☐ Treatment Plan including services being requested along with the frequency and duration

COMMENTS

(Please provide a detailed explanation in support of your First Request)

SECTION 3. HEALTH CARE PROVIDER RESPONSE TO FIRST REQUEST

PROVIDER

- ☐ Additional information has been provided - Attach Supporting Documentation
- ☐ Additional information has not been provided - Provide explanation below

EXPLANATION