

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## REQUEST FOR AUTHORIZATION OF TREATMENT OR TESTING BY AUTHORIZED MEDICAL PROVIDER

### Standing Order of the State Board of Workers' Compensation

Advance authorization for the medical treatment or testing of an injured employee is not required by the Georgia Workers' Compensation Act as a condition for payment of services rendered. However, an authorized medical provider may request advanced authorization for treatment or testing by completing Sections 1 and 2 of this form and faxing or e-mailing same to the insurer/self-insurer. The insurer/self-insurer shall respond to this request within 5 business days of receipt of this form by completing Section 3 below. If the insurer/self-insurer fails to respond to this request within the 5-day period, the treatment or testing stands pre-approved. See, Board Rule 205. **NEITHER THE REQUEST NOR THE RESPONSE SHALL BE FILED WITH THE BOARD, UNLESS OTHERWISE REQUESTED.**

Honorable Carolyn C. Hall, Chairman  
State Board of Workers' Compensation

SECTION 1. IDENTIFYING INFORMATION					
<b>PATIENT</b>	Last Name	First Name	M.I.	Social Security Number	Date of Accident
Employer Name			Insurer / Self-Insurer Name		
Adjuster			Insurer/Self-insurer phone number		
Insurer/Self-insurer E-mail			Insurer/Self-insurer Fax number		

SECTION 2. REQUEST FOR TREATMENT OR TESTING AUTHORIZATION					
Diagnosis		ICD-9 Code	Requested Treatment or Testing		
CPT/DRG Code	Who is to provide treatment or testing?		Reason for treatment or testing		
Requesting authorized medical provider				Address	
Phone Number		Fax Number		City	
E-mail				Sate	Zip Code
I hereby certify that this completed form was <input type="checkbox"/> Faxed <input type="checkbox"/> Emailed                     to the Insurer / Self-Insurer on this the _____ day of _____, _____ (year)					
Signature of Authorized Requesting Medical Provider					

SECTION 3. RESPONSE OF INSURER TO REQUEST FOR TREATMENT OR TESTING AUTHORIZATION	
(Check appropriate item(s) and return to requesting Medical Provider by Fax or E-mail)	
<input type="checkbox"/> The requested Treatment or Testing is authorized <input type="checkbox"/> The requested Treatment or Testing is not authorized because it is: <input type="checkbox"/> a. Not related to the on-the-job injury <input type="checkbox"/> b. Not reasonably required to effect a cure, give relief or restore employee to suitable employment <input type="checkbox"/> c. Not being provided by an authorized, panel or referral medical provider; <input type="checkbox"/> d. Additional information needed (specify) <input type="checkbox"/> e. Other (specify)	
I hereby certify that this Response was <input type="checkbox"/> Faxed <input type="checkbox"/> Emailed                     to the requesting medical provider on this the _____ day of _____, _____ (year)	
Signature of Insurer/Self-Insurer Representative	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

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Advance authorization for the medical treatment or testing of an employee is not required by the Workers' Compensation Act. However, in the event an authorized provider requests pre authorization/pre-certification for treatment or tests of an employee and submits this form for such preauthorization/pre-certification to the insurer/self-insurer, the insurer/self-insurer shall respond, in writing, to this request within 5 business days from its receipt. A written request or response under this subsection shall be by facsimile transmission or e-mail. Any response to this request shall be sent directly to the requesting authorized medical provider. If the insurer/self-insurer fails to respond by completing Section 3 of this form within 5 business days, the treatment or testing stands pre-approved.

**Neither the request nor the response shall be filed with the Board, unless otherwise requested.**

In the event the insurer/self-insurer furnishes an initial written refusal to authorize the requested treatment or testing within the 5 business day period, then within 21 days of the initial receipt of the request for the requested treatment or testing, the insurer/self-insurer shall either:

- (a) Authorize the requested treatment or testing in writing; or
- (b) File with the Board a Form WC-3 controverting the treatment or testing and set forth the specific grounds for the controversion.

Advance authorization procedures for medical providers participating in a Board approved WC/MCO may be governed by the applicable contract and may vary from the provisions above. Questions regarding the applicability of the provisions above should be addressed to the plan administrator or Managed Care Division of the State Board of Workers' Compensation (404) 656-3784.

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