

ANNEXURE C: FIRST REHABILITATION / AUTHORISATION REPORT**1 AUTHORISATION REQUEST FORM**

Please indicate your request type with an X:

First rehabilitation report		Extension of treatment period required	
Additional treatment session required		Amendment to treatment codes required	

V

Surname:	
First Name:	
Identity Number:	

EMPLOYER DETAILS

Name of Employer:	
Date of Injury / Onset of symptoms:	

REFERRING DOCTOR DETAILS

Referring Doctor:	
Referring Doctor Practice Number:	
Telephone Number:	
Email address:	

Dated referral letter stipulating reason for the referral and referring doctor stamp and signature has been included with this pre-authorisation request.	YES	NO
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SUPPORTING DOCUMENTS ATTACHED TO PRE-AUTHORISATION REQUEST ONLY IF CLAIM NOT REGISTERED

Please indicate attached documents with an X (only attach if necessary):

WCL2		WCL4		ID	
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INJURY / SYMPTOM DETAILS

ICD 10 Code:	
Diagnosis:	

CURRENT PRESENTATION

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REHABILITATION PLAN**A. REHABILITATION PLAN***Ensure that the treatment goals are specific and measurable with outcome measurements.*

1.	
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2.	
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10.	

B. ANTICIPATED DURATION AND FREQUENCY OF TREATMENT INCLUDE DATES

Overall expected duration of treatment intervention:	
Overall expected number of treatment sessions:	
Frequency of treatment intervention (daily; bi-daily; weekly etc)	

C. ANTICIPATED CODING FOR ABOVE TREATMENT SESSIONS

CODE:	QUANTITY	CODE:	QUANTITY

MOTIVATION FOR CHANGE IN AUTHORISATION REQUEST (COMPLETE ONLY IF NOT THE FIRST REHABILITATION REPORT)
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SERVICE PROVIDER DETAILS

Name:	
Practice Number:	
Date of initial consultation:	
Date of pre-authorisation request:	
Telephone Number:	
Email address:	
Signature:	