WORKERS' COMPENSATION TREATMENT PLAN

Insurance Carrier Information:	PATIENT:
	Phone:
	DOI:
	Claim No.:
Adjuster Name/Phone:	Employer:

CURRENT DIAGNOSIS:
PROGNOSIS: ☐ Poor ☐ Fair ☐ Good ☐ Pending
SUBJECTIVE FINDINGS:
OBJECTIVE: Continuation of massage therapy to reduce pain and improve function level

**Pursuant to Section 12-15-32 of the Administrative Rules related to Workers' Compensation Medical Fee Schedule, I hereby request authorization for medical treatment and/or continued medical treatment for the named claimant/injured party.

REFERRED TO:	**SPECIALTY:**	**PHONE:** (808) 201-7514
Ion Wellness / Lenora Carras, LMT	Massage Therapy	**FAX**: (808) 441-3105

TREATMENT DESCRIPTION: Massage Therapy

SPECIFIC TIME SCHEDULE OF MEASURABLE OBJECTIVES:

1. Baseline measurement at start of treatment plan:
   PAIN (Least>Most) 0 1 2 3 4 5 6 7 8 9 10

2. Projected goal at the end of the treatment plan:
   PAIN (Least>Most) 0 1 2 3 4 5 6 7 8 9 10

FREQUENCY & DURATION: ☐ _____ visit(s) per week for_____weeks (*EST. COST Pursuant to Medical Fee Schedule)

PROJECTED START AND END DATE(S) OF TREATMENT(S): From To:

PHYSICIAN:

SIGNATURE: DATE:

FOR COMPLETION BY INSURANCE ADJUSTER
☐ APPROVED ☐ Denied / Reason for Denial:
Adjuster:______________________________Date:____________________