

MCARE

Schedule "D"

Primary Level Authorization to Treat – Massage Therapy

To: Saskatchewan Workers' Compensation Board

From:

_____ (name of clinic)
_____ (name of therapist)
_____ (address of clinic)

Telephone Number: _____ Fax Number: _____

Re:

Client: _____ **Claim Number:** _____

Employer: _____ **Area of Injury:** _____

Date of Injury: _____ **PHN:** _____

This patient has been referred for massage therapy by licensed practitioner _____

(Please attach referral document)

(Name)

I am requesting authorization to provide ____ treatments. (Not to exceed 5 treatments)

WCB PERSONNEL: Please indicate your decisions regarding funding below:

WCB decision re request for funding of treatment:

- Approved
- Denied
- Provisional authorization Treatment is being funded while adjudication occurs.
- Treatment is being funded pending receipt of referral document.

WCB decision re funding for reports: The following report fee will be funded:

- Initial Assessment
- Progress Report (where an extension of the originally approved treatment is requested)
- Discharge Summary
- NO reports required by WCB at this time

Date

Case Manager

Telephone Number