



MCARE

Primary Level Authorization to Treat – Psychology and Occupational Therapy

To: Saskatchewan Workers' Compensation Board

From: Name of clinic: _____

Name of care provider: _____ Professional designation: _____

Address of clinic: _____

Telephone: _____ Fax: _____

Re: **Worker:** _____ **Claim number:** _____

Employer: _____ **Area of injury:** _____

Date of injury: _____ (dd/mm/yy) **Provincial Health Number:** _____

This patient has been referred by _____ for the primary level services checked off below (please attach referral document except where you are a direct access care provider):

Occupational therapy – specify proposed treatment: _____

Psychology – specify proposed treatment: _____

Other: _____

Expected number of treatments: _____

WCB personnel: Please indicate your decision regarding authorization to treat below and fax this form back to the requesting care provider.

Approved

Denied

Provisional authorization – treatment will be funded until adjudication decision is made.

(dd/mm/yy)

Date

Case manager

Telephone

