



**MCARE**

**Primary Level Authorization to Treat – Massage Therapy**

**To: Saskatchewan Workers' Compensation Board**

**From:** Name of massage therapy clinic: \_\_\_\_\_

Name of massage therapist: \_\_\_\_\_

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 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 decision 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 the WCB at this time

(dd/mm/yy)

\_\_\_\_\_

**Date**

**Case manager**

**Telephone**

