|  |  |
| --- | --- |
| Date of Letter | **Treatment Decision** |

Enter Claimant Name

Claimant Address Line 1

Claimant Address Line 2

Claimant Address Line 3

RE: Claim Enter Claim Number

Dear Enter Claimant Name,

This notice is about your treatment recommendations received from enter provider’s name.

We have received a request for authorization for Click or tap here to enter text, procedure code(s) Click or tap here to enter text. The requested treatment is select one for the following reasons:

Mandatory free text box.

If you have questions about the action being taken, or have additional information you’d like to provide, please contact me at the phone number listed below.

Sincerely,

|  |  |  |
| --- | --- | --- |
| Name |  | Enter Phone Number |
| Name |  | Phone Number |

|  |
| --- |
| **If you dispute the action being taken, you may write the Department of Labor & Industries within 60 days at:**  **Department of Labor & Industries**  **PO Box 44892**  **Olympia WA 98504-4892**  **Fax: 360-902-6900**  **Or go to: https://secure.Lni.wa.gov/ReportSelfInsuredEmployer/#** |

cc: Attending Provider