



Provider name			Date mailed/faxed
Address	City	State	Nine-digit ZIP Code

Injured worker name	Claim number	Date C-9 received
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Dear Dr.

We have received the Physician's Report/Treatment Plan for Industrial Injury or Occupational Disease (C-9). Your request is pending until we receive the following medical documentation. Please submit the documentation checked below and return it within 10 business days to allow for a treatment decision.

- 1. History and physical indicating causal relationship to treatment requested
- 2. Progress note/office notes
- 3. Emergency department report
- 4. Radiology report interpretation
- 5. Hospital admission history and physical
- 6. Operative report
- 7. Discharge summary Inpatient-Outpatient
- 8. Discharge Plan Inpatient
- 9. Pathology Laboratory report
- 10. NCV EMG EKG interpretation
- 11. Consultation report-second opinion report
- 12. Rehabilitation summary
- 13. Physical therapy treatment report
- 14. POR (physician of record) name and address
- 15. Psychiatric treatment summary
- 16. Other _____

Comments: _____

Claim Inactive: We may dismiss request if documentation not received.

Please return the requested documentation to the attention of:

MCO company/SI employer name (please print, type or stamp).		FAX number ()	Telephone number ()	
Address	City	State	Nine-digit ZIP Code	

Thank you for your prompt attention and for the care given to Ohio's injured workers.