Date of Letter

Treatment Decision

Enter Claimant Name
Claimant Address Line 1
Claimant Address Line 2
Claimant Address Line 3

New

RE: Claim Enter Claim Number

Switch

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.
(Removed sentence)
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 ← **New**

Or go to: http://secure.Lni.wa.gov/ReportSelfInsuredEmployer/# ← **Updated**

cc: Attending Provider