

{Date}

{Physician's or authorized nurse practitioner's name}

{Street address}

{City, state, ZIP}

## Elective Surgery Response

Re: Worker name: \_\_\_\_\_ Claim number: \_\_\_\_\_

### Insurer's response to elective surgery notification

We received your request for elective surgery for this worker (check one box).

**Box #1** ☐

We approve your request for (list specific surgery): \_\_\_\_\_

**Box #2** ☐

We have scheduled a consultant exam with \_\_\_\_\_ on \_\_\_\_\_  
to evaluate whether the proposed surgery is medically reasonable to treat the compensable injury. The  
consultation must be completed within 28 days from the date of this notice. We will notify you of the consultant's  
findings within seven days of the completed consultation.

**Box #3** ☐

We disapprove the proposed surgery and no consultant exam is requested (list specific surgery): \_\_\_\_\_

### Physician or authorized nurse practitioner

If the insurer checks:

**Box #1** You may proceed with the proposed surgery.

**Box #2** When you receive the consultant's findings and the consultant physician agrees with the proposed surgery, you may proceed with the surgery. If the consultant physician disagrees with the proposed surgery, you may contact the insurer to try to reach an agreement about the proposed surgery. **If you do not reach an agreement and continue to recommend the proposed surgery, sign and date below, and return this form to the insurer (keep a copy).**

\_\_\_\_\_  
*Physician's or authorized nurse practitioner's signature*

\_\_\_\_\_  
*Date*

**Box #3** You may contact the insurer to try to reach an agreement about the proposed surgery. **If you do not reach an agreement and continue to recommend the proposed surgery, sign and date below, and return this form to the insurer (keep a copy).**

\_\_\_\_\_  
*Physician's or authorized nurse practitioner's signature*

\_\_\_\_\_  
*Date*

If the insurer believes the proposed elective surgery is excessive, inappropriate, or ineffectual, the insurer must request administrative review by the director of the Department of Consumer and Business Services within 21 days of the insurer's receipt of this signed form. Failure by the insurer to timely respond to the physician's or authorized nurse practitioner's elective surgery request, or to timely request administrative review, bars the insurer from later disputing whether the surgery is or was excessive, inappropriate, or ineffectual.

{Insert insurer's name, address, and phone  
number}

cc: