|  |  |  |  |
| --- | --- | --- | --- |
| **Logo  Description automatically generated** | |  | |
| **▶ TYPE OF SERVICE**  **Initial Clinical Review:**  **Prospective  Expedited** (72 hrs)  **Concurrent  Retrospective**  **Peer Clinical Review:**  **Appeal**  **Peer-to-Peer Phone Mtg**  **File Review / Internal Use** |  | **▶ REQUEST**  UTILIZATION REVIEW (CA) REFERRAL FORM  **Normal** (Before day 3)  **Rush** (Day 4 or after)  (Call EK; All medical reports due before 3:00pm)  **▶ REQUEST NEEDS**  **PT/OT  DME**  **Psychiatric  Injection**  **Surgery  Other:** | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Carrier Receipt Date of DWC Form RFA: ­** | | | | | | **Date Referral Submitted to EK Health:** | | | |
| **Claim Ref. #:** | | | | | | **D.O.I.:** | | | |
| **WCIS # (Required):** | | | | | | **EAMS # (required, if litigated):** | | | |
| **Injured Worker – *Print Last Name in CAPS*** | | | | | | | | | |
| LAST NAME: | | | | | | First Name: | | | |
| Phone: | | | | | | D.O.B.: | | | |
| Address: | | | | | | Last 4 Digits SSN: | | | |
| Date of Hire: | | | Language: | | | Job Title: | | | |
|  | |  | | | |  | | | |
| **Carrier – Address report to:** | | | | | | **Carrier – Bill Report to:** | | | |
| Adjuster: | | | | | | Other Contact: | | Phone: | |
| Email: | | | | | |  | | | |
| Company: | | | | | | Company: | | | |
| Address: | | | | | | Address: | | | |
|  | | | | | | | | | |
| **Employer:** | | | | | |  | | | |
| Company: | | | | | |  | | | |
|  | | | | | | | | | |
| **Additional Information:** | | | | | | | | | |
| Accepted Body Parts: | | | | | Denied Body Parts: | | | | |
| Reason for Review: | | | | | | | | | |
| ICD-9 Code(s): | | | | CPT Code: | | | | | |
|  | | | | | | | | | |
| **Providers:** | | | | | | | | | |
| Primary Treating Provider: | | | | | | Requesting Provider: | | | |
| Specialty: | | | Tax ID: | | | Specialty: | Tax ID: | | |
| Phone: | | | Fax: | | | Phone: | Fax: | | |
| Address: | | | | | | Address: | | | |
|  | | | | | |  | | | |
| **Attorneys:** |  | | | | |  | | |  |
| Applicant: | | | | | | Defense: | | | |
| Phone: | | | Fax: | | | Phone: | Fax: | | |
| Email: | | | | | | Email: | | | |
| Address: | | | | | | Address: | | | |

**By signing below, I acknowledge I am authorized to make this referral on behalf of the Carrier and agree to the pricing of the Billing Guidelines and the Referral Terms and Conditions as published on** [**HERE**](https://ekhealth.com/terms-and-conditions/)

**Signature: Date:**