|  |  |
| --- | --- |
| **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:**