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|  | **TYPE OF SERVICE** |
|  | **Initial Clinical Review:** **[ ]  Prospective** **[ ]  Concurrent** **[ ]  Expedited** (72 hrs) **[ ]  Retrospective** | **Peer Clinical Review:****[ ]  Appeal** **[ ]  Peer-to-Peer Phone Mtg****[ ]  File Review / Internal Use**  |
| **Utilization Review****CA Referral Form****Please submit via** Fax at (408) 725-1135, or Email: ekur@ekhealth.com | **REQUEST NEEDS** | **REQUEST IS****[ ]  Normal** (Before day 3) **[ ]  Rush** (Day 4 or after. Call EK; All medical reports due before 3:00pm) |
|  |  | **[ ]  PT/OT** **[ ]  Psychiatric****[ ]  Surgery** **[ ]  DME****[ ]  Injection** | **[ ]  Medication****[ ]  Chiropractic****[ ]  Diagnostics****[ ]  Other** |

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| **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:  | First:  |
| Phone:  | D.O.B.:  | Language:  |
| Address:  | SSN:  |
| Date of Hire:  | Job Title:  |
|  |  |
| **Carrier – Address report to:** | **Carrier – Bill Report to:** |
| Adjuster:  | Other Contact:  |
| Email:  | Phone:  | Email:  | Phone:  |
| Company:  | Company:  |
| Address:  | Address:  |
|  |
| **Employer:** |
| Company:  |
|  |
| **Additional Information:** |
| Accepted Body Parts: |
| Reason for Review:  |
| ICD-9 Code(s):  | CPT Code:  |
|  |  |
| **Providers:**  |  |
| Primary Treating Provider:  | Requesting Provider:  |
| 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** [**www.ekhealth.com/component/article/432**](www.ekhealth.com/component/article/432)**.**

**Signature: Date:**