|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | **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** | |

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