PREFERRED MANAGEMENT CORPORATION

5465 Vista Del Mar, Yorba Linda, CA 92887/Tel: (909)597-2167 ext 1/Fax: (866)735-1252

UTILIZATION REVIEW REFERRAL FORM

FAX TO 866-735-1252

Date received UR request: **Date faxed to UR dept:**

Section I - CLAIMANT INFORMATION (Sections I-VI to be completed by claims examiner)

Claimant Name: _____ Claim #: _____

Claimant Address: _____ Date of Injury: _____

_____ Date of Birth: _____

Claimant Phone: _____ Social Security:

Section II - ADJUSTER / CLIENT / BILLING INFORMATION

Adjuster Name: _____ Email Address: _____

Adjuster Phone: _____ Fax: _____

Insurance Name / Address: _____

Section III - EMPLOYMENT INFORMATION

Employer: _____

Employer Phone: _____ Claimant Occupation: _____

Section IV - PROPOSED PROCEDURE

Requested Procedure(s): _____

Diagnosis: _____

Surgery Date: _____ In-Pt or Out-pt: _____

Body Part(s) Accepted: _____

Section V – ATTORNEY INFORMATION

Applicant Attorney Name: _____ Defense Attorney Name: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Address: _____ Address: _____

_____ _____

Section VI – COMMENTS – SERVICES TO BE REVIEWED (text)

PTP / **Specialty**: _____ Requesting MD / **Specialty**: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

PT / DME Name: _____ Phone: _____

Nurse Case Manager: _____ Phone: _____ Fax: _____

Please fax over the last narrative report describing the UR request along with the prescription, diagnostics and any other beneficial information. COMMENTS MAY CONTINUE ON 2ND PAGE: