



Authorization Request

Fax this completed form to:
(775) 850-8138 or Toll Free (800) 356-1448

Patient/Claim Data

Date: _____

Patient Name: _____ Claim Number: _____

Social Security Number: _____ Date of Injury: _____ Patient Age: ____

Body Part(s): _____ Gender: Male Female

Employer (required): _____ Patient Working? Yes No

Authorization Data

Requesting Physician: _____ Tax ID: _____

Diagnosis: _____

ICD-9 Code (required): _____

Requested service(s), procedure(s), or diagnostic test(s)(required) _____

CPT Code (required): _____

Surgeon: _____ Assistant: _____

Anesthesia Group: _____

Facility: _____ Requested Length of Stay: _____

Provider Contact Information

Return Auth to: _____ Phone: _____

Fax Number: _____ e-mail address: _____

PLEASE ATTACH MEDICAL REPORTING/OBJECTIVE FINDINGS TO SUPPORT THIS REQUEST

For Internal Use Only

Clinical Protocol: _____ Approved

Signature: _____ Date: _____

Revised 4 03

Authorization expires 30 days from the date authorization is given if approved services have not been performed. Additional services require a written request and medical rationale. This authorization is not a guarantee of payment. The injured worker must receive claim acceptance notification from EICN. Medical service determinations do not ensure claim acceptance. EICN reserves the right to deny liability for the injury or condition after the reports and circumstances of the injury are thoroughly reviewed. Medical billings are subject to review and approval or denial based upon medical services rendered and proper coding. By submitting this Authorization Request, the Provider represents and warrants that Provider is currently licensed and the requested services are within the scope of Provider's license. Provider agrees to submit copy of license upon request. This form is available online at www.employers.com