Request for Authorization

SUPPORTING DOCUMENTATION IS REQUIRED TO PROCESS THIS REQUEST.

FAX the completed form to: (702) 671-7676

☐New Request ☐Resubmission – Change in Material Facts ☐Expedited Review: Check box if employee faces an imminent and serious threat to his or her health ☐ Check box if request is a written confirmation of a prior oral request.			
Employee Information			
Name (Last, First, Middle):			
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):	
Claim Number:		Employer:	
Requesting Physician Information			
Name:			
Practice Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
Specialty:		TIN/NPI Number:	
E-mail Address:			
Claims Administrator Information			
Company Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number: (702) 671-7676	
Requested Treatment (Attach additional pages if necessary)			
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.			

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)

Requesting Physician Signature:	Date: