Surgery, Diagnostic or Ancillary Service Request

Date: _____ Claim #: _____ DOI: _____ DOB: _____

Injured Worker's name: _____

Name of physician recommending procedure: _____

Name of contact person: _____

Email of Contact Person: _____

Office phone: _____ Fax: _____

List injured/treated body part, right/left/bilateral:

_____

_____

Surgery recommended:_____

Facility name: _____

Patient has been counseled on the effects of nicotine: ☐ Yes ☐ No

Is any post-operative durable medical equipment needed: ☐ Yes ☐ No

If yes, list all post-operative durable medical equipment:

_____

_____

Diagnostic test recommended:

_____

_____

Facility name: _____

Injections recommended:

_____

_____

Number of Injections: _____ Frequency of Injections: _____

Other treatment recommendations:

_____

_____

Facility Name: _____

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