

# Excel Managed Care & Disability Services, Inc.

## Utilization Review Request

8300 Fair Oaks Blvd. #404  
Carmichael, CA 95608  
Phone: (888) 464-0044  
Fax: (916) 944-0211  
Excelmanagedcare.com

Date: \_\_\_\_\_

**ADJUSTER NAME:** \_\_\_\_\_

**INSURANCE CARRIER:** \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Telephone #: \_\_\_\_\_

Fax#: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Claim Number:** \_\_\_\_\_

Date of Injury: \_\_\_\_\_

**Employer Name:** \_\_\_\_\_

**Requesting Physician:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Treating Physician Phone#: \_\_\_\_\_

Treating Physician Fax#: \_\_\_\_\_

**INJURED WORKER/CLAIMANT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone #: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Occupation: \_\_\_\_\_

Male  Female

**Accepted Body Part (s):** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

\_\_\_\_\_

ICD-9: \_\_\_\_\_

**Service/Procedure Requested:** \_\_\_\_\_

\_\_\_\_\_

**CPT code(s):** \_\_\_\_\_

**Date of Service/Procedure Request:** \_\_\_\_\_ (REQUIRED)

**SPECIAL INFORMATION:** Prior treatment(s), for how long and with what result?

Please attach all available pertinent progress notes, consult notes, laboratory/diagnostics/ x-ray results.