Utilization Review
Authorization Request

- **Please complete this information and fax to 877-922-7236**
- **Please also attach the clinical information necessary to substantiate the request.**
- **Direct questions to Sedgwick Utilization Review 866-286-0281**

Sender's name: _____ **Date of Request:**_____

Phone: ( ) _____ **Fax:** ( ) _____

Patient's Name:	**Date of Injury:**	**DOB:**
Claim #	**SSN:**	
Employer:		

Requesting Physician:	**Facility Name** (if indicated):
Specialty: _____	Specialty: _____
Address: _____	Address: _____
City/St/ZIP: _____	City/St/ZIP: _____
Phone: ( ) _____	Phone: ( ) _____
Fax: ( ) _____	Fax: ( ) _____
Tax ID Number _____	Tax ID Number _____

Diagnosis:	**ICD Codes:**	**Date of Service:**
Procedure(s) Requested:		
CPT code(s):		
Medications Requested:		
Qty, D/S, Frequency:		