

Impairment  
Rating  
Specialists



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**Primary Treating Physician's Referral for Final Impairment Report**

Date:	Applicant: Applicant Tel :
Carrier:	Social Security #:
Adjuster Name:	Date of Injury:
Adjuster Tel:	Date of Birth:
Adjuster Fax:	Claim#:
Adjuster Email:	Body Location(s) Authorized:
UR Fax:	Referring Doctor/Clinic:

**I am requesting authorization for a one time consult to perform a Validated Certified Comprehensive Final Written Ratable Permanent and Stationary Report/ML 102 for purposes of final adjudication of this applicant's claim.**

**Referring Provider Name:** \_\_\_\_\_

**Referring Provider Signature:** \_\_\_\_\_

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

**Fax Request for Consultation to 206-338-3005, please save your fax receipt.**

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