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.