Herbert Perliss, MD, QME/Psychiatry

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Employee:	**Employee Tel. No.:**
Employee Address:	
Carrier:	**SSN:**
Adjuster Name:	**Date of Injury:**
Adjuster Tel:	**Date of Birth:**
Adjuster Fax:	**Claim No.:**
Adjuster Email:	**Body Location(s) Authorized:**
UR Fax:	**Referring Doctor/Clinic:**

Primary Treating Provider's Request

I am requesting authorization for Comprehensive Medical-Legal Psychiatric Evaluation (ML104) on this employee.

Referring Provider Name: _____

Referring Provider Signature:_____

Date:_____

Fax Request for Consultation to 530-666-5601, please save your fax receipt.