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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.

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