Fax to: 1-916-781-5595 **OR** **Email to: ncmur@intermedccs.com**

UR Assignment	☐ **Yes**	☐ **No**	**Nurse Case Management**	☐ **Yes**	☐ **No**

Your Date of Knowledge:	**Today's Date:**
Adjuster:	**Phone #:**
Claim #:	**Date of Injury:**
Mechanism of Injury:	
WCIS Jurisdiction Claim #:	**EAMS #** (if applicable)**:**
Claimant Name:	
Date of Birth:	**Social Security #:**
Street Address:	**City:**
Phone No:	**State& Zip:**
Insured:	
Applicant Attorney:	**Phone #:**
Address:	**Fax #:**
Defense Attorney:	**Phone #:**
Address:	**Fax #:**
Requesting Provider:	**Phone #:**
Street Address:	**Fax #:**
City:	**State &Zip:**
Treatment/Procedure To Be Reviewed: (be specific)	
Accepted Body Part(s):	
Will you dispute this request?:	☐ **Yes** ☐ **No**
Primary Treating Physician:	**Phone #:**
Address:	**Fax #:**
Vendor: (if applicable)	**Phone #:**
Address:	**Fax #:**

Please attach all reports pertinent to this request *(i.e. diagnostic reports, most recent reports or PR 2, AME, etc.)*

Comments / Instructions:

InterMed Use Only:

Date of Knowledge _____ Date Received by UR _____ Add'l Info? _____ Due Date: _____