TRISTAR MANAGED CARE

P.O. Box 10220, Santa Ana, CA 92711-0220
(877) 626-7827 Option 5, 2 ▪ Fax (562) 506-0355
Email: tmc.casemgmt@tristargroup.net

REQUEST FOR SERVICE – GROUP HEALTH MEDICAL REVIEW

DATE: _____

Insurer Branch/ Location: _____

Adjuster Name: _____

Adjuster Phone: _____
Adjuster Fax: _____
Adjuster Email: _____

Insured Name: _____
Insured SS#: _____
Insured Employer: (Address, Phone) _____
Insured Policy #: _____

Relationship to Patient: _____

PATIENT INFORMATION:

Insured Policy Number: _____

Patient Name: _____
Patient Address: _____

Daytime Phone #: _____
Social Security #: _____
Gender: _____
Date of Birth: _____

Medical History: _____
ICD9/CPT Codes: _____

PHYSICIAN/FACILITY INFORMATION:

Treating Physician: _____

Address: _____
Contact Person _____

Facility Name: _____
Facility Address: _____
Facility Phone/Fax: _____

Admission Date: _____
Discharge Date: _____

PPO Name: _____

☐ GROUP HEALTH Utilization Review

- ☐ Prospective
- ☐ Concurrent
- ☐ Retrospective

☐ GROUP HEALTH –Telephonic Management –Discharge Planning

- ☐ Disease Management
- ☐ Medical Prescreen
- ☐ Psychiatric Case Management
- ☐ Disability Case Management

***** Mandatory Field for UR*****

Treatment Requested CPT Procedure Code and Procedure Description: _____

Admission and Discharge Date _____

Physician Requesting Treatment: _____

Type of Plan Coverage:

Special Instructions/Reason for Assignment/Objectives to CM and Comments (be as specific as possible):

TMC Office Use Only

TMC File No:	Date:	Case Manager Name: