genex
AN ENLYTE COMPANY

Pharmacy Intervention Referral Form

Referral Email: cpr@genexservices.com
If file size is over 20MB, please contact PRIUM and SFTP access will be set up for secure sending.

Claimant Information:

First Name: **Last Name:**

Employer:

Phone: **Date of Birth:** **Gender:** M F

Address:

City: **State:** **ZIP:**

Referring ASM:

Claim Information:

Claim Number: **Date of Injury:**

Jurisdiction:

Accepted Conditions and Body Part(s):

Denied Conditions and Body Part(s):

Disputed Conditions and Body Part(s):

Adjuster Information:

Adjuster Name: **Email Address:**

Phone: **Fax:**

Billing Address:

City: **State:** **ZIP:**

Case Manager Information:

Case Manager Name: **Email Address:**

Phone: **Fax:**

Address:

City: **State:** **ZIP:**

Attorney Information:

Applicant Attorney (if represented):

Phone: **Fax:**

Address:

City: **State:** **ZIP:**

Additional Information (specific issues or concerns):

Medical Records and Documentation Submitted

- Most recent 6 months of PBM data and/or paper bills
- Physician Progress Reports covering the most recent 6-12 months
- Case Management notes within the last 12 months
- Utilization Review determinations within the last 12 months
- Recent Operative Reports (if applicable)
- Patient Release (if one is one file)
- First Report of Injury
- Drug testing results from within the last 12 months
- Any recent IME/AME/QME
- MSA
- Surveillance
- Relevant legal documentation (if applicable)

Submit Reset