Expedited Case Review Request Form

Denial Date: (MM/DD/YYYY)
Date Submitted: (MM/DD/YYYY)
Claimant Name:
Claim Administrator Claim No.:
Date of Birth: (MM/DD/YYYY)
Date of Injury: (MM/DD/YYYY)
Date Received by the Department (For Department Use Only):

Petitioner Name:
Address/City/State/Zip:
Phone:
Relationship to Claimant:

Treating Physician Name:
Address/City/State/Zip:
Contact Person:
Phone:

Insurer Name:
Address/City/State/Zip
Phone:

Why would denial of further dispensing of already prescribed medication(s) pose a risk of a medical emergency?

What documentation have you submitted in support of your request?
(Please list and provide a copy of medical records to support your Expedited Case Review request.)

DRAFT