Funding Medical Procedures in Personal Injury Cases

PATIENT PROCEDURE REQUEST FORM

Date:________________ Referring Medical Center:____________________________________
Referring Chiropractor: ____________________________________

PATIENT INFORMATION

Patient Name: __________________________________ Patient Phone #________________________

Date of Birth:____________________________ Date of loss:_________________________________

MEDICAL PROCEDURE INFORMATION

Description of Procedure:____

Date of Procedure: _________Facility contact:____________Facility Fax Number:_______________

Cost Estimate: ______________________CPT Code: ____

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PHYSICIAN INFORMATION

Name of Physician (referring Physician): ____

Phone Number: _______________ Fax Number:________________ Contact: ____________________

ATTORNEY INFORMATION

Attorney Name: ____

Contact Name: ______________Phone Number: _____________Fax Number:___________________

Once you have completed the above information, please fax to (702) 382-4260

____

ACCEPTANCE

Accept:_________________ Date:____________________

Deny:__________________

By:____, Sierra Med Services.
If approved, said approval shall be valid for ONLY thirty (30) days from date of approval.
Invoice for procedure must be submitted for payment within twenty (20) days of procedure.

Phone: 702.382.3272 Fax: 702.382.4260
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