

**AR UR
CERTIFICATION
NUMBER: 0205**

SYSTEMEDIC CORPORATION

Managed Care Programs
10809 Executive Center Dr., Suite 105
Little Rock, AR 72211-6020
Phone: (501) 227-5553
Toll Free: (800) 822-2680
Fax: See Boxes

Please Check One:
 Workers' Compensation
 Health
 Auto Liability
 Gen Liability
 Other: _____

SYM # _____

BASIC REFERRAL DATA	Claims Rep _____ Ins Co/Payer: _____	Attorney <input type="checkbox"/> None Name: _____ Phone: _____
	CLAIMANT (B, C or D services) _____	
	Claim # (B, C or D services) _____	
Date: _____	Claimant SS # _____	
Your Phone: _____	If workers' comp, please attach <i>First Report of Injury</i> and Release of Information Authorization.	

A

<input type="checkbox"/> PROVIDER BILL REVIEW Doney Williams FAX: 227-6954	<input type="checkbox"/> Please audit all attached bills per AR Fee Schedule
	<input type="checkbox"/> Please audit attached single bill per AR Fee Schedule Claimant _____

B

<input type="checkbox"/> HOSPITAL BILL AUDIT Doney Williams FAX: 227-6954	<input type="checkbox"/> Prescreen/Fee Schedule <input type="checkbox"/> Prescreen & Audit If Indicated <input type="checkbox"/> Full Audit
	<input type="checkbox"/> Separate charges unrelated to _____ Return medical bills to acct.? <input type="checkbox"/> Yes <input type="checkbox"/> No Return medical records to acct.? <input type="checkbox"/> Yes <input type="checkbox"/> No PLEASE INCLUDE ORIGINAL (OR COPY) OF INVOICE, ANY HOSPITAL RECORDS OR MEDICAL RECORDS.

C

<input type="checkbox"/> RN TELEPHONE CASE MGMT, UR, PEER REVIEW, FILE REVIEW Evonne Nusz FAX: 978-2050	Please check any areas for special RN attention:		
	<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Estimated Cost of Treatment	<input type="checkbox"/> Alternatives to Current Treatment
	<input type="checkbox"/> Estimated Prognosis	<input type="checkbox"/> Appropriateness of Current Treatment	<input type="checkbox"/> Recommendations
	<input type="checkbox"/> Estimated Recovery Time	<input type="checkbox"/> Possible Complications	<input type="checkbox"/> Need for Medical Case Mgmt.
	<input type="checkbox"/> Other _____		
	Primary Physician: _____	City: _____	Phone: _____

D

<input type="checkbox"/> ON-SITE RN MEDICAL CASE MGMT Susan Harding OR <input type="checkbox"/> VOCATIONAL SERVICES Tom Strickland FAX: 227-8362	Claimant's Address _____		
	Phone # _____ Date of Injury _____		
DOB _____ Occupation _____ Weekly Wage \$ _____			
Diagnoses: 1) _____ 2) _____			
Physician: _____	Physician: _____	Physician: _____	
City: _____	City: _____	City: _____	
Specialty: _____	Specialty: _____	Specialty: _____	

Special Instructions, Comments, Observations from Referring Party:

Please call me about this referral

Please send a supply of Referral Forms