



THE LIEN SOLUTIONS PROGRAM FORM PHYSICIAN PROCEDURE REQUEST

PATIENT INFORMATION

Male Female

SS#: _____ - _____ - _____

Patient Last Name: _____ First: _____ M.I.: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Alternate Number: _____

Date of Injury: _____ Appointment/Procedure Date: _____ Time: _____

PROCEDURE

Type and Body Part

Radiology: MRI _____ contrast: with withoutCT _____ contrast: with without

Other _____

Surgery: Outpatient _____

Inpatient _____

Pain Management: Procedure _____

Level _____

Consultation: _____

Other: _____

Facility where procedure is to be performed (if known): _____

PHYSICIAN INFORMATION

Requesting Physician: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Contact Name: _____

Physician is treating patient on (check all that apply): P.I. Lien Medpay Health Ins. _____

PERSONAL INJURY ATTORNEY INFORMATION

Attorney Name: _____ Contact Person: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

LIABILITY INSURANCE CARRIER INFORMATION

Carrier Name: _____ Claim #: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Special Instructions: If applicable, please fax this form with the treating physician's prescription.

Key Health offers a choice of two or more providers. Key Health does not direct medical care, nor offer any determinations for medical necessity. Key Health, through its primary business, may assist in the identification of providers who treat patients on a Lien/Letter of Protection status.

Physician Signature: _____ Date: _____

Please complete the above information and fax to: (877) 539-54365601 LINDERO CANYON ROAD • SUITE 220 • WESTLAKE VILLAGE, CALIFORNIA 91362
TELEPHONE (877) 633-5436 / (877) MED-LIEN
FAX (877) 539-5436 / (877) KEY-LIEN