**Request For Utilization Management Review  
or Case Management Services**

Date Submitted:

Group Name:

Name of Submitter:

Email of Submitter:

Telephone Number:

**Information or Assistance Requested:**

UM Retrospective Review (*Prefer faxes only to 1-800-510-2162*)

UM PreDetermination Review (*Faxes to 1-800-510-2162 or email to* [*healthlinkmedmgmtrequests@healthlink.com*](mailto:healthlinkmedmgmtrequests@healthlink.com)*)*

**Email the following to** [**healthlinkmedmgmtrequests@healthlink.com**](mailto:healthlinkmedmgmtrequests@healthlink.com)

Case Management Referral

Reinsurance Report

Other – Please describe the assistance requested:

**Requested Member Information:**

Member Name:

Member ID:

Member Date of Birth:

Extension of Benefits:  Yes  No

Please provide any additional information to assist with the completion of the request: