**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**)*

**Email the following to** **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: