Out-of-Network Referral Request

Referring Treating Doctor

Injured worker name		
Address		
Insurance carrier & Employer		
Claim number		
Date of injury		
Out-of-Network Referral/Provider Information		
Referral/Provider name		
Referral/Provider address		
Referral/Provider phone & fax		
Current Treating Doctor's Information		
Treating Doctor's name		
Treating Doctor's address		
Treating Doctor's phone & fax		

Treating doctor's reason for requesting an out-of-network referral:

_____

_____

_____

_____ _____

Treating Doctor's Signature (**Required)** Date

Once completed, this form should be mailed or faxed to the claims adjuster.
Please attach any additional medical records that will substantiate this request. You will be notified in writing of the outcome of the review within seven calendar days from the receipt of your request.

Adjuster response

Decision	☐ Approved ☐ Denied* ☐ Other (see rationale below)	
Decision rationale		
Network name	CompKey +	
Adjuster name		
Phone/fax numbers		
Adjuster: Please forward a copy of the decision to the network		

*Appeals process: Appeals may be filed with the network: CompKey Plus, 10535 Boyer Blvd Ste. 100, Austin TX 78758. Fax: (800) 580-3123, Phone (800) 580-1314, Email: compkey@careworksmcs.com. Access the network complaint/appeal form online at https://www.carework.com.