



(2) **Other Use(s)** (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

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This request is being submitted:

Pre-Claim

Post-Claim. If checked, please attach the claim or indicate the claim number \_\_\_\_\_

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

\_\_\_\_\_  
Name and Title of Provider or Provider Representative Completing  
Form and Attestation (Please Print)\*

\_\_\_\_\_  
Date

**\*The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**

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Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.