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|  | **ADS Intake Request Form** |  |
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| **Employer Group** | Enter Employer here | **Third Party Administrator** | Sedgwick |
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| **Member Information** |
|  |
| **Member First Name** | Enter First Name here | **Member Last Name** | Enter Last Name here |
|  |
| **MRN or HRN** | Enter MRN or HRN here | **Member Date of Birth** | Enter DOB Here |
|  |
| **Member Address Line 1** (Street Address, P.O. Box) | Enter Street Address here |
|  |
| **Member Address Line 2** (Apartment, Suite Unit) | Enter Apt. or Unit # here |  |
|  |
| **City** | Enter City here | **State** | State  | **Zip Code** |  Zip Code |
|  |
| **Member Email Address** | Enter Email here | **Member Phone Number** | Phone Number |
|  |
| **Date Range Requested - FROM** | Enter From Date | **Date Range - TO** | Enter To Date |
|  |
| **First Day of Absence** | Enter FDOA here | **Diagnosis/Medical Condition** | Enter Diagnosis here |
|  |
| **Claim Number** | Enter Claim # here | **This request is for** | All Records |
|  |
| **Requestor Information** |
|  |
| **Name of Requestor** | Enter Requestor here | **Phone number of Requestor** | Requestor Phone here |
|  |
| **Requestor / Correspondence Email Address** | Enter Requestor email here |
|  |
| **Email Address for Medical Records** | CalabasasFax@Sedgwick.com |
|  |
| **Description** (Add any additional information if necessary) | Enter Description Here |
|  |
| **Type of Request** | New Request |
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| **\*Required Information (Valid Authorization form must accompany the request).****Return Request Intake Information Form to:**Absence Documentation Services (ADS)**Via email @:** **ADSREQUESTS@kp.org**Please contact us with any questions at: (888)900-9093 |
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