# Date Extension Request Form

**Landmark Healthcare, Inc.**,1750 Howe Ave., Suite 300, Sacramento, CA 95825 **FAX (800) 599-8350**

| **Date of this Request** |
|---|
| ___/___/_____ |

**INSURED**

| Patient Last Name | Patient First Name | M.I. | Gender ☐ M ☐ F | Age | Date of Birth (MM/DD/YYYY) _____/_____/_____ |
|---|---|---|---|---|---|
| Insured I.D. or SSN | Insured Last Name | M.I. | First Name | | Patient Phone (area code first) |
| Patient Address | City | | State | | Zip Code |

**PAYOR**

| Employer Name | Insurance Company | Group Plan # or Union Local (Submit Copy of Patient's Insurance I.D. Card) |
|---|---|---|
| Injury or illness is related to: ☐ Work ☐ Auto ☐ Other | Does the patient have other insurance that might cover this injury/illness? ☐ Yes ☐ No | If applicable, other carrier's name: |

**DOCTOR**

| Doctor Last Name | Doctor First Name | M.I. | Area Code + Phone ( ) | Area Code + Fax ( ) |
|---|---|---|---|---|
| Doctor Address | City | State | Zip Code | Doctor License # |

**TX PLAN**

| **Authorization Reference No.** | **Dates Previously Authorized** (MM/DD/YYYY) Start Date ____/_____/_____ End Date ____/_____/_____ | **Request to Extend Through** (MM/DD/YYYY) ____/_____/_____ Not to exceed 30 days from the end date previously authorized. |
|---|---|---|

Submit this date extension request within 30 days of the previously approved treatment plan end date. Otherwise, please submit an updated Treatment Plan form.

I declare that the above information is true and correct to the best of my knowledge.

Signature _____ Date_____

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