

Case Management Referral Form



Referral Date:

Case Category (check all that apply):

<input type="checkbox"/> Telephonic	<input type="checkbox"/> Task Only	<input type="checkbox"/> Worker's Comp
<input type="checkbox"/> On Site	<input type="checkbox"/> Non-Subscriber	<input type="checkbox"/> Liability
<input type="checkbox"/> Group Health	<input type="checkbox"/> Other: _____	

Employee Information:

Employee Full Name:		
Claim #:		
DOB:		SSN:
Date Of Injury:		Date Of Hire:
Address:		
City:	State:	Zip Code:
Phone (with area code):		Cell Phone (with area code):
Email Address (if necessary):		
Occupation:		
Type of Injury/ body part:		
Description of accident:		

Employer and Insurance Information:

Employer:	TPA/Insurance Co.:
Contact:	Adjuster:
Address:	Address:
City/ST/Zip:	City/ST/Zip:
Phone:	Phone:
Cell Phone:	Cell Phone:
Fax:	Fax:
E-mail:	E-mail:

Employee Provider and/or Legal Representation Information:

Provider:	Provider:
Address:	Address:
City/ST/Zip:	City/ST/Zip:
Phone:	Phone:
Fax:	Fax:

Activity Requested/Comments:

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For Office Use Only:
Case Manager Assigned:
Initial Report Due Date:

For your convenience, fax completed form to

Toll Free: (888) 891-2368