Medical Case Management Referral Form

Requested Medical Case Manager:

Date Referred:

Injured Worker: ______________________

Address: ______________________

______________ ____ ______________

Phone:

Occupation:

Claim Number:

S.S. Number: | D.O.I.:

AWE: | D.O.B.:

Injury/Illness:

Claims Adjustor: ______________________

Carrier/TPA: ______________________

Address: ______________________

City, State, Zip: ______________ ____ ______________

Email Address: ______________________

Phone: FAX:

Employer/Insured: ______________________

Address: ______________________

City, State, Zip: ______________ ____ ______________

Contact Person: ______________

Phone: ______________

Contact: ____Yes ____No

Treating Physician: ______________________

____

Hospital/Group: ______________________

Address: ______________________

City, State, Zip: ______________ ____ ______________

Phone: FAX:

Applicant Attorney: ______________________

Firm: ______________________

Address: ______________________

City, State, Zip: ______________ ____ ______________

Phone: FAX:

____ **Task**

____ **Full Med**

Status Updates: ________Phone ________Email

Defense Attorney: ______________________

Firm: ______________________

Address: ______________________

City, State, Zip: ______________ ____ ______________

Phone: FAX:

Special Instructions:

Fax Referral to: 209-491-5199