



MEDICAL CASE MANAGEMENT REFERRAL FORM
FAX TO 866-591-7541

CLAIMANT INFORMATION:

Claimant Name: _____ DOI: _____
Injury/Diagnosis: _____ Claim #: _____
SSN: _____ Beginning TD Date: _____ Wkly TTD Rate: _____
Last Day Worked: _____ Home Phone #: _____ DOB: _____
Address: _____
Street City State Zip

SERVICES REQUESTED:

FCM _____ TCM _____ LCP _____ Ergo Eval _____

PROPOSED PROCEDURE

Proposed Procedure: _____
Surgery Date: _____ Admission Date: _____ ICD-9 Code(s): _____

EMPLOYER INFORMATION:

Employer: City of Glendale Occupation: _____
Contact Person: _____ Phone #: _____
Address: _____
Street City State Zip

PHYSICIAN INFORMATION

Treating MD: _____ Phone #: _____
Specialty: _____ Fax #: _____
Address: _____
Street City State Zip

ATTORNEY INFORMATION

Applicant Attorney: _____ Phone #: _____
Address: _____
Street City State Zip

ADJUSTER/BILLING INFORMATION:

Adjuster Name: _____ Phone #: _____
Company Name: _____ Fax #: _____
Email Address: _____ Date of Referral: _____
Address: _____
Street City State Zip

IMPORTANT INFORMATION: WHY REFERRED TO MCM (NOTES MAY CONTINUE ON 2ND PAGE)