**▶ CARRIER**

CASE MANAGEMENT REFERRAL FORM

**[ ]  Address Bill to [ ]  Address Report to**

 **Adjuster:**

**Phone:**

**Email:**

**Company:**

**Street Address:**

**City, State & Zip:**

**▶ REFERRAL**

**Injured Worker:**

**Phone:**       **DOB:**

**SSN:**

**Street Address:**

**City, State & Zip:**

**Claim #:**

**WCAB Board and #:**

**DOI:**
**Jurisdiction:**

**▶ EMPLOYER**

**Employer Name:**       **Current Job:**

**Employer Contact & Phone #:**       **Last Day Worked:**

**AWW (Average Weekly Wage):**

**▶ HEALTHCARE PROVIDER**

**Treating MD:**

**Phone:**       **Fax:**

**Street Address:**       **City, State & Zip:**

**▶ MEDICAL CONDITION/INJURY**

**ICD code(s):**

**Accepted Body Part(s):**       **Denied Body Part(s):**

**▶ ATTORNEYS**

**Applicant AAL:**

**Phone:**       **Fax:**

**Street Address:**

**City, State & Zip:**      **Defense AAL:**

**Phone:**       **Fax:**

**Street Address:**

**City, State & Zip:**

**▶ SERVICES**

|  |  |  |
| --- | --- | --- |
| **[ ]  CM: Telephonic (Full)** | **[ ]  CM: Task Assignment** | **[ ]  Ergonomic Evaluation** |
| **[ ]  CM: Telephonic (Limited)** | **[ ]  Discharge Planning**  | **[ ]  Cost Projection** |
| **[ ]  CM: Field (Full)** | **[ ]  Next Step Medical Advisory ProgramSM** | **[ ]  Peer Review** |
| **[ ]  CM: Field (Limited)** | **[ ]  Prescription Intervention Program** | **[ ]  Job Analysis** |
| **[ ]  CM: Catastrophic** | **[ ]  Life Care Planning** | **Other:**       |
| **Is a Spanish-speaking nurse required? Yes [ ]  No [ ]**  |  |
| **Nurse Requested** *(full name)***:**       |  |

**▶ Reason for Referral:**

***By typing my name below I am authorized to make this referral on behalf of the Carrier and agree to the pricing of the Billing Guidelines and the Referral Terms and Conditions as published*** [***HERE***](https://ekhealth.com/terms-and-conditions/)***.***

 **NAME:       DATE:**