

UMC Medical Consultants, PC

Case Management Referral Form

2700 Westchester Avenue • Purchase, NY 10577

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DATE OF ASSIGNMENT _____ Date Copied: _____ By: _____

TYPE OF CLAIM: W/C _____, Liability _____, Auto _____, Disability _____, Health _____, Other _____

ACCOUNT INFORMATION:

Adjuster / Referral Source: _____ Company: _____

Address: _____

Phone Number: _____ Ext.: _____ Fax: _____

Claim #: _____ WCB # (if applicable) _____

E-MAIL Address: _____

CLAIMANT INFORMATION:

Name: _____ Phone: _____ DOB: _____

Address: _____

SS#: _____ Type of Injury: _____ DOI: _____

OCCUPATIONAL DATA:

Employer: _____ Job Title: _____

Address: _____ Weekly Wages: _____

_____ Contact Person: _____

Contact Phone Number: _____

TREATING PHYSICIAN:

CLAIMANT ATTORNEY:

Name: _____

Name: _____

Address: _____

Address: _____

Phone / Fax: _____

Phone / Fax: _____

SERVICE(S) REQUESTED:

- | <u>Code</u> | | <u>Code</u> | |
|-------------|---|-------------|-------------------------------------|
| _____ 10 | Telephonic Case Management | _____ 16 | 15-8 Review |
| _____ 11 | Medical Field Case Management | _____ 30 | Vocational Services (explain below) |
| _____ 12 | Medical Task Assignment (explain below) | _____ 40 | MRI / Diagnostic Review |
| _____ 13 | File Review | _____ | |
| _____ 14 | Medical Cost Projection | _____ 61 | FCE |
| _____ 15 | Life Care Plan | _____ 910 | Other Telephonic |

COMMENTS / SPECIAL INSTRUCTIONS: _____ Other Assignment (explain below)