Case Management Referral Form

UMC Headquarters:
100 Elwood Davis Road, Suite 106 • North Syracuse, NY 13212
Phone • 877-862-4463 • Fax 315-453-2884

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:

Name: _____

Address: _____

_____

Phone / Fax: _____

CLAIMANT ATTORNEY:

Name: _____

Address: _____

_____

Phone / Fax: _____

SERVICE(S) REQUESTED:

Code		Code	
_____	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)