** CARRIER**

CASE MANAGEMENT REFERRAL FORM

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

**Adjuster:**

**Company:**

**Phone:**

**Email:**

**Street Address:**

**City, State & Zip:**

**REFERRAL**

**Injured Worker:**

**Phone:**       **DOB:**

**SSN:**

**Street Address:**

**City, State & Zip:**

**Claim #:**

**WCAB Board and #:**

**DOI:**       **Jurisdiction:**

 **EXCESS CARRIER *(OR OTHER CONTACT FOR FILE UPDATES)***

**Name:** **Company:**

**Phone:**       **Email:**

 **EMPLOYER**

**Employer Name:**       **Current Job:**       **Last Day Worked:**

**Employer Contact:**       **Phone:**  **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)** | **[ ]  Discharge Planning** | **[ ]  Cost Projection** |
| **[ ]  CM: Telephonic (Limited)** | **[ ]  Next Step Medical Advisory ProgramSM** | **[ ]  Job Analysis** |
| **[ ]  CM: Field (Full)** | **[ ]  Physician Advisor Review** | **Other:**       |
| **[ ]  CM: Field (Limited)** | **[ ]  Life Care Planning** |  |
| **[ ]  CM: Catastrophic** | **[ ]  Ergonomic Evaluation** |  |

**Nurse Requested** *(full name)***:**       **Spanish-speaking nurse required? [ ]  Yes [ ]  No**

***Is there anyone at EK Health that recommended or assisted you in making this referral?***

 **▶ 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:**