



Referral Sheet
Medical Case Management

Fax referral form to 256-532-2778 Date of Referral: _____

T.P.A./Insurance Company: _____

Referring Claims Adjuster: _____ Claim Number: _____

Mailing Address: _____

Billing Address: _____

Telephone Number/Extension: _____ Fax Number: _____

Injured Worker: _____

Address: _____

Home Telephone Number: _____ Social Security Number: _____

Date of Birth: _____ Date of Hire: _____ Weekly Wage: _____ Date of Injury: _____

Employer: _____ Contact: _____

Address: _____ City/State/Zip Code: _____

Telephone Number: _____ Fax Number: _____

Treating Physician: _____

Address: _____ City/State/Zip Code: _____

Telephone Number: _____ Fax Number: _____

Diagnosis: _____

Attorney Information (if represented): _____

Telephone Number: _____ Fax Number: _____

Address: _____

City/State/Zip Code: _____

Comments/Special Instructions:

Office Use: Date Received: _____ Case Manager: _____