

EXCEL MANAGED CARE & DISABILITY SERVICES, INC.

REFERRAL FOR SERVICE FORM

California: 8300 Fair Oaks Blvd. #404
Carmichael, CA 95608
Phone: (916) 944-7185
Fax: (916) 944-0211
Toll Free: (888) 464-0044 or emcnds@excelmanagedcare.com

Services Requested: (Please place a check mark next to the type of referral)

- | | |
|---|--|
| <input type="checkbox"/> FCM = Medical Field Case Management | <input type="checkbox"/> QRR = 90 Day |
| <input type="checkbox"/> TASK = Medical Task Assignment (1 Visit) | <input type="checkbox"/> Ergo= Ergo Evaluation |
| <input type="checkbox"/> TCM = Telephonic Case Management | <input type="checkbox"/> JA = Job Analysis |

Special Comments or Instructions: _____

Referral Date: _____

Referred By: _____

Adjuster: _____

Email Address: _____

Account Name: _____

Address: _____

Acct Tel #: _____

Acct Fax #: _____

Injured/III Client

Name: _____

Address: _____

Client Tel #: _____

SSN: _____ DOB: _____

Client Job Title: _____

Coverage Type: _____

Claim #: _____

Date of Injury: _____

Last Day Worked: _____

Injury Description: _____

Diagnosis: _____ (ICD-9)

Wages at Injury: _____

Compensation Rate: _____

Employer Name: _____

Address: _____

Employer Tel #: _____

Employer Fax#: _____

Employer Contact Person: _____

Physician Name: _____

Address: _____

Physician Tel #: _____

Physician Fax #: _____

Applicant Attny: _____

Address: _____

Applicant Attny Phone #: _____

Applicant Attny Fax #: _____

Defense Attny: _____

Address: _____

Defense Attny Phone #: _____

Defense Attny Fax #: _____