

EXCEL MANAGED CARE & DISABILITY SERVICES, INC.

3840 Watt Avenue, Bldg. C, Suite 200, Sacramento, CA 95821

Phone: 916-944-7185 or Toll Free: 888-464-0044

REFERRAL FOR SERVICE FORM

Fax Referral Form To: (916) 944-0211 or Email To: 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 |
| <input type="checkbox"/> RTW = Return to Work Referral | <input type="checkbox"/> 24 Hour = 24 Hour On Call Referral |

Special Comments or Instructions: _____

Referral Date: _____

Referred By: _____

Adjuster Name: _____

Adjuster Email Address: _____

Account Name: _____

Address: _____

Adjuster Tel #: _____

Adjuster Fax #: _____

Coverage Type: _____

Claim #: _____

Date of Injury: _____

Last Day Worked: _____

Injury Description: _____

Diagnosis: _____ (ICD-9)

Wages at Injury: _____

Compensation Rate: _____

Applicant Attny: _____

Address: _____

Applicant Attny Phone #: _____

Applicant Attny Fax #: _____

Injured/III Client

Name: _____

Address: _____

Client Tel #: _____

SSN: _____ DOB: _____

Client Job Title: _____

Employer Name: _____

Address: _____

Employer Tel #: _____

Employer Fax#: _____

Employer Contact Person: _____

Physician Name: _____

Address: _____

Physician Tel #: _____

Physician Fax #: _____

Defense Attny: _____

Address: _____

Defense Attny Phone #: _____

Defense Attny Fax #: _____