IA LOGO HERE

RECOMMENDED VENDOR REQUEST FOR SERVICE FORM

Request for Service

Referral By:

Adjuster Name: _____ Phone: _____
Email: _____ Fax: _____

Claimant Information

Claim Number: _____ Date of Injury: _____
Claimant Name: _____ Date of Birth: _____
Claimant Address: _____ _____ _____
City State/Zip
Work Phone: _____ Home Phone: _____
Employer Name: _____ Occupation: _____
Job Description: _____
_____
Injury Description: _____
_____
_____

Claimant Work Status: ☐ Off Work ☐ Modified Duty ☐ Full Duty

Claimant is represented: ☐ Yes ☐ No

Treating Physician Information:

Name: _____ Phone: _____
Address: _____ Fax: _____

Purpose of Assignment:

☐ Catastrophic medical management
☐ Compensability Issue Resolution
☐ Coordinate multiple vendors
☐ Medical Maximum Improvement Determination
☐ Medical Necessity Determination
☐ Modified Duty Assistance
☐ Negotiation of DME or Home Health Providers
☐ Permanent Disability Determination
☐ Post-surgical recommendations
☐ Prescription Review
☐ Records acquisition
☐ Utilization Review
☐ Other _____

Additional Comments: _____
_____

Authorized by:

_____ _____
Signature Date

Accepted by:

_____ _____
Signature Date

Note: Return this signed form to Adjuster before beginning services.