Case Management Referral Form

Referral Date:

Case Category (check all that apply):

☐ Telephonic CM	☐ Field CM	☐ Task Only	☐ Nonsubscriber	☐ Worker's Comp
☐ Other: _____				

Employee Information:

Employee Full Name:		
Claim #:		
DOB:	SSN:	
Date Of Injury:	Date Of Hire:	
Address:		
City:	State:	Zip Code:
Phone (with area code):	Cell Phone (with area code):	
Email Address (if necessary):		
Occupation:		
Type of Injury/ Body Part:		
Description of Accident:		

Employer and Insurance Information:

Employer:	TPA/Insurance Co.:
Contact:	Adjuster:
Address:	Address:
City/ST/Zip:	City/ST/Zip:
Phone:	Phone: ext.
Cell Phone:	Direct Phone:
Fax:	Fax:
E-mail:	E-mail:

Employee Provider and/or Legal Representation Information:

Provider:	Provider:
Address:	Address:
City/ST/Zip:	City/ST/Zip:
Phone:	Phone:
Fax:	Fax:

Activity Requested/Comments:

For Office Use Only:
Case Manager Assigned:
Initial Diary Due Date:

For your convenience, fax or email completed form to:
referrals@proactivecm.net
FAX: 888.891.2368