StatCare, LLC

Service Referral

Claimant: **Referral Date:** **StatCare File #:**

CLAIMANT INFORMATION:

SSN: Claim #:
Name:
Address:

County:
Phone #:
DOB: Gender: Marital Status:
Education: Language:
Occupation:
Date of Injury: Date Hired:
Dx./ICD9:
Injury State: MD WCC #:
Avg Wkly Wage: Wkly Benefit:

INSURED PERSON:

SSN: Relation to Clmt:
Name:
Address:

EMPLOYER INFORMATION:

Contact:
Company:
Address:

Phone #:
Fax #:

INSURED COMPANY:

Company:
Address:

Phone #:
Fax #:

ADDITIONAL INFORMATION:

ASSIGNED TO:

Tx. to: As of:
Tx. to: As of:

1ST REPORT DUE:

REFERRAL SOURCE:

Contact:
Company:
Address:

Phone #:
Fax #:
e-mail:

SECONDARY CONTACT:

Name:
Company:
Address:

Phone #:
Fax #:

TREATING PHYSICIAN INFORMATION:

Name:
Facility:
Address:

Phone #:
Fax #:
Specialty:

ATTORNEY:

Name:
Facility:
Address:

Phone #:
Fax #:

ADDITIONAL PROVIDER:

Name:
Facility:
Address:

Phone #:
Fax #:

SERVICE:

☐ **OCM** ☐ **Task** ☐ **IME Coord** ☐ **Other**

Service Instructions: Level 1