MCM

MICHIGAN CASE MANAGEMENT

Providing Health and Disability Solutions

a division of Castle Rock Case Management

REFERRAL FORM

Phone 877-627-6267 | Fax 810-227-8115 | contact@micmservices.com | micmservices.com

Date of Referral	Date of Injury	Case Manager	Telephonic Case Mgmt.	Medical	Vocational	Task Assignment	Direct Referral	Date Received (Office Use)
			☐	☐	☐	☐	☐	

ACCOUNT INFORMATION

Company:
Contact:
Address:
City/State/Zip:
Telephone:
Fax:
E-Mail:
Copies to:
Referral source (if different than above):

CLIENT INFORMATION

☐ **Male** ☐ **Female**

Name:
Social Security #:
Address:
City/State/Zip:
Telephone:
Date of Birth:
Occupation:
Claim #:
Diagnosis:
ICD-10 Code(s):

TYPE OF CLAIM

☐ Workers' Comp. ☐ Auto - PIP
☐ LTD / STD ☐ Group Health
☐ Market Survey ☐ Other

If Auto - PIP: ☐ Primary ☐ Coordinated

If Other, specify:

TREATING PHYSICIAN

Name:
Address:
City/State/Zip:
Telephone:
Next Appt. Date: **Time:**

EMPLOYER INFORMATION

Employer:
Contact:
Address:
City/State/Zip:
Telephone:
Fax:

ATTORNEY

Name:
Address:
City/State/Zip:
Telephone:
Fax:
E-Mail:

COMMENTS / SPECIAL INSTRUCTIONS

Initial Report Due:

CONFIDENTIAL: Contains protected health information.