

## REQUEST FOR SERVICE

### Purpose of Referral:

#### Review *Works* Cost Containment Services

- Medical Bill Review
- Hospital Bill Review
- Utilization Management – Peer Review
- PPO Re-Pricing
- Out-of-Network Negotiations
- Other

#### Review *Works* Disability Management Services

- First Report of Injury
- Catastrophic Case Management
- Medical Case Management
- Telephonic Case Management
- Medical Cost Projection
- Vocational Case Management
- Labor Market Assessment
- Job Club
- Other

**ReviewWorks Cost Containment Request for Service**

Date of Referral \* \_\_\_/\_\_\_/\_\_\_\_\_ Service Requested

**INSURANCE COVERAGE**

- Auto
- WC
- Liability
- LTD
- Other \_\_\_\_\_

State of Jurisdiction\* \_\_\_\_\_

**CLAIM REPRESENTATIVE INFORMATION**

Claims Representative\* \_\_\_\_\_

Company\* \_\_\_\_\_

Mailing Address\* \_\_\_\_\_

City\* \_\_\_\_\_

State\* \_\_\_\_\_ Zip\* \_\_\_\_\_

Phone\* \_\_\_\_\_

E-Mail\* \_\_\_\_\_

**CLAIMANT OR PATIENT INFORMATION**

Name\* \_\_\_\_\_

Date of Birth\* \_\_\_/\_\_\_/\_\_\_\_\_ Date of Injury\* \_\_\_/\_\_\_/\_\_\_\_\_

Claim Number\* \_\_\_\_\_

Injuries\* \_\_\_\_\_

**SPECIAL INSTRUCTIONS OR COMMENTS**

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Please fax, mail or e-mail images of the related medical bills, release of medical information, first report of injury and pertinent medical records.

Phone 248.848.5100 Fax 248.848.9506 or [info@reviewworks.com](mailto:info@reviewworks.com).

**SUBMIT NOW**

**PRINT COPY**

Review **Works** Disability Management Request for Service

Date of Referral \* \_\_\_/\_\_\_/\_\_\_ Service Requested

**INSURANCE COVERAGE**

Auto \_\_\_ WC \_\_\_ Liability \_\_\_ LTD \_\_\_ Other \_\_\_

State of Jurisdiction\* \_\_\_\_\_

**CLAIM REPRESENTATIVE INFORMATION**

Claims Representative\* \_\_\_\_\_

Company\* \_\_\_\_\_

Mailing Address\* \_\_\_\_\_

City\* \_\_\_\_\_

State\* \_\_\_\_\_ Zip\* \_\_\_\_\_

Phone\* \_\_\_\_\_

E-Mail\* \_\_\_\_\_

**CLAIMANT OR PATIENT INFORMATION**

Name\* \_\_\_\_\_

Date of Birth\* \_\_\_/\_\_\_/\_\_\_ Date of Injury\* \_\_\_/\_\_\_/\_\_\_

Claim Number\* \_\_\_\_\_ SS # XXX - XX - \_\_\_\_\_

Occupation\* \_\_\_\_\_

Average Weekly Wage \_\_\_\_\_ Last Day Worked \_\_\_/\_\_\_/\_\_\_

Insured \_\_\_\_\_

Diagnoses\* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Address\* \_\_\_\_\_

City\* \_\_\_\_\_

State\* \_\_\_\_\_ Zip\* \_\_\_\_\_

Phone\* \_\_\_\_\_

**EMPLOYER INFORMATION**

Employer Contract \_\_\_\_\_  
Company \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_

**MEDICAL INFORMATION**

Hospital \_\_\_\_\_  
Hospital Contact \_\_\_\_\_  
Attending Physician \_\_\_\_\_  
Physician Phone \_\_\_\_\_  
Medical Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ATTORNEY INFORMATION**

Attorney Name \_\_\_\_\_  
Law Firm \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Attorney Notified YES \_\_\_\_\_ NO \_\_\_\_\_

**SPECIAL INSTRUCTIONS OR COMMENTS**

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