

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

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 248.305.7057 or 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 _____

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