



## Auto No Fault/PIP or Workers' Compensation Referral

### Referral Contact Information

Date of Referral: \_\_\_\_\_

Referred By (name): \_\_\_\_\_

Title: \_\_\_\_\_

Company/Organization: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

### Adjuster/Examiner Information

Full Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Branch/Location: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Region: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

### Case Manager Information (if applicable)

Full Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Case Manager's Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

### Claimant/Patient Information

SSN: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_



# Northwood

Claim Number: \_\_\_\_\_

## Auto No Fault/PIP or Workers' Compensation Referral

Home Phone #: \_\_\_\_\_ Alt. Phone #: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender:  M  F

### Claim Information

Date of Injury: \_\_\_\_\_ ICD-9: \_\_\_\_\_

Injury Related Diagnosis: \_\_\_\_\_ State Jurisdiction of Injury: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer State: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Zip: \_\_\_\_\_

### Auto No Fault/PIP or Workers' Compensation Insurance Information

Carrier/Payer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Coordination of Benefits (if applicable):  Yes  No

Other Insurance Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Service/Plan Code: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Coverage Limits: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

### Physician Information

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_ Doctor's Fax: \_\_\_\_\_



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### Authorized Services

- |   |  |
|---|--|
| <input type="checkbox"/> DME                        | <input type="checkbox"/> Home Health Care      |
| <input type="checkbox"/> Home Modification          | <input type="checkbox"/> Infusion/I.V. Therapy |
| <input type="checkbox"/> Interpretation/Translation | <input type="checkbox"/> Medical Supplies      |
| <input type="checkbox"/> Prosthetics & Orthotics    | <input type="checkbox"/> Transportation        |
| <input type="checkbox"/> Other                      |  |

Date Services Needed: \_\_\_\_\_

Authorized Length of Service: \_\_\_\_\_

### Comments