

# **Professional Care Management & Consulting**

**Phone: (814) 769-6246 Fax: (814) 238-3898**

## **Service Request Sheet**

### **Claims Information**

Client Name	
Referral Source	
Telephone	
FAX	
Email	
Address	
City	
State	
ZIP	

### **Employee Information**

First Name	
Middle Name	
Last Name	
Telephone	
Address	
City	
State	
ZIP	
County	
Claim Number	
Date of Birth	
Date of Injury	
Date of Hire	
SSN	
Occupation	
Physician(s)	
Treatment County	
Diagnosis	

### **Employer Information**

Employer	
Contact	
Telephone	
FAX	

Email	
Address	
City	
State	
ZIP	
<b>Attorney Information</b>	
Defense Attorney	
Telephone	
FAX	
Email	
Address	
City	
State	
ZIP	
Plaintiff Attorney	
Telephone	
FAX	
Email	
Address	
City	
State	
ZIP	
<b>Referral Information</b>	
• Field Case Management	• Catastrophic claim
• Telephonic Case Management	• Chronic pain claim
• File Review/Triage	
• Task Assignment	
• IME Coordination	
• Cost Analysis	
• Other	
<b>Special Instructions</b>	
Assigned to	
Date Assigned	
Date RTW	
Date Reopened	
Notes	