HOOVER
Complete Workers' Compensation Management Since 1979…

CORPORATE OFFICE
1970 Technology Parkway
Mechanicsburg PA 17050
Phone 717.728.5502 Toll Free 1.800.692.7294
Fax 717.728.5504 Visit www.hooverinc.com

URAC ACCREDITED CASE MANAGEMENT

DATE REFERRED_____

ACCOUNT REPRESENTATIVE

_____

SERVICE REQUEST

Please check the service(s) requested and specify as appropriate

☐ **Workers' Comp** ☐ **Auto**

☐ Medical Management (Specify)_____

☐ Vocational Management (Specify)_____

☐ Medical Invoice Repricing ☐ Telephonic Case Management ☐ Peer Review

☐ Independent Medical Examination ***Click here to complete required IME Referral Section***

☐ MSA ☐ Life Care Plan ☐ Cost Projection ***Click here to complete required MSA/Life Care Plan/Cost Projection Referral Section***

☐ Other Services (Specify)_____

THE FOLLOWING INFORMATION IS REQUIRED FOR ALL REFERRALS:

Referred By_____Company_____

Address_____City/State/Zip_____

Phone_____Ext_____Fax_____Email_____

Has claim been accepted? ☐ Yes ☐ No Claim No._____WC Jurisdiction_____

INJURED WORKER INFORMATION

Name_____Age_____DOB_____DOI_____

Address_____City/State/Zip_____

Home Phone_____Mobile Phone_____Email_____

INJURED WORKER'S EMPLOYMENT INFORMATION

Is the injured worker currently working? ☐ Yes ☐ No Position/Occupation_____

Employer Name_____

Employer Address_____City/State/Zip_____

Employer Phone_____Contact_____Ext_____Email_____

INJURED WORKER'S ATTORNEY INFORMATION

Attorney Name_____Firm_____

Address_____City/State/Zip_____

Phone_____Ext_____Fax_____Email_____

INJURY/PHYSICIAN INFORMATION

Injury Type/Description_____

Other Complaints_____

Treating/Attending Physician_____Hospital_____

Has Injured Worker had an IME? ☐ Yes ☐ No Date of Last IME_____IME Physician_____

Additional Instructions/Notes

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SERVICE REQUEST

IME REFERRAL SECTION *Please provide the following information for all IME referrals.*

(If you have not already done so, remember to complete the primary Service Request on Page 1.) ***Click here to return to Page 1.***

DEFENSE ATTORNEY INFORMATION **Is a defense attorney assigned?** ☐ Yes ☐ No

Attorney Name_____Firm_____

Address_____City/State/Zip_____

Phone_____Ext_____Fax_____Email_____

☐ Check here if you would like a copy of the appointment letter to go the defense attorney.

COVER LETTER/ISSUES TO ADDRESS AT EXAMINATION (Check all that apply)

☐ Injury history and treatment
☐ Prior injuries and/or pre-existing conditions
☐ Do objective findings support subjective complaints?
☐ Present status
☐ Comprehensive physical examination including non-physiologic findings
☐ Diagnosis ☐ Prognosis
☐ Can IW return at this time with no restriction?
☐ What are IW's physical capabilities?
☐ Has IW achieved Maximum Medical Improvement?
☐ Is there any permanency of injuries or residuals?
☐ Is current treatment reasonable and necessary?
☐ Is further treatment needed? If so, what kind, for what length of time and at what frequency?
☐ Causal relationship of the injuries to the accident/incident.

APPOINTMENT PREFERENCES - If you have a physician preference or specific scheduling needs, please provide the following information:

IME Provider/Practice_____Specialty_____

Address_____City/State/Zip_____

Phone_____Ext_____Fax_____Email_____

Appointment Timeframe_____Report Timeframe_____

List the Name(s) of Treating Physician(s)_____

Are Medical Records Available ? ☐ Yes ☐ No Delivery Method_____

OTHER ISSUES

☐ IW will need transportation to/from appointment ☐ IW will need translation services

Comments/Notes_____

_____

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MSA – LIFE CARE PLAN – COST PROJECTION SECTION

Please provide the following information for all MSA/LCP referrals.

(If you have not already done so, remember to complete the primary Service Request on Page 1.) ***Click here to return to Page 1.***

ADDITIONAL CLAIMANT INFORMATION

Social Security No._____Medicare No._____

Address_____City/State/Zip_____

Phone_____Ext_____Fax_____Email_____

DEFENSE ATTORNEY INFORMATION

Is a defense attorney assigned? ☐ Yes ☐ No

Attorney Name_____Firm_____

Address_____City/State/Zip_____

Phone_____Ext_____Fax_____Email_____

CASE INFORMATION

1. Briefly describe the injury (i.e., how it occurred).

2. What is the specific nature of the accepted injury?

3. What was the claimant's job title or duties at the time of injury?

4. Is the claimant currently receiving Social Security Disability benefits? ☐ Yes ☐ No
5. Is the claimant currently eligible for Medicare benefits? ☐ Yes ☐ No
6. Does the claimant continue to receive indemnity benefits? ☐ Yes ☐ No
7. Have indemnity benefits been settled? ☐ Yes ☐ No
8. Have settlement negotiations begun? ☐ Yes ☐ No

If yes, what is the estimated settlement value? $

9. Please provide claimant's current work-related prescription medications, with dosages and use frequency: (NOTE: Disregard if claimant receives all prescription medications through KeyScripts.

	DRUG NAME	DOSAGE	FREQUENCY
1.			
2.			
3.			
4.			
5.			

NOTES/SPECIAL INSTRUCTIONS

PLEASE PROVIDE THE FOLLOWING INFORMATION WITH THIS COMPLETED REFERRAL FORM:

1. First Report of Injury/Occupational Injury Form
2. Medical records/reports from claimant's treating physician(s) during the past 2 years, and any other prior medical records providing insight to current medical status
3. Medical invoices and EORs
4. IME reports
5. Medical payment history from the date of injury
6. Indemnity payment history from the date of injury
7. Copy of claimant's Medicare card, if available
8. Copy of all prior rated ages, if available
9. Supporting settlement documentation; Bureau decisions, if applicable

For questions regarding MSA/LCP & Cost Projection referral, please contact:

Terry Folk, CRC, CDMS, CCM, CLCP, MSCC
Phone 1.800.692.7294 Ext. 2127 Fax 717.728.5505
Email tfolk@hooverinc.com

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