REHAB AT WORK-Corporate
It's Our REHAB That WORKS
30 W. Gude Drive, Suite 230
Rockville, Maryland 20850
P: 301-838-2040 F: 301-838-2041
Corporate@rehabatwork.com

Patient's Name: _____ **SSN:** XXX-XX-
Sex: _____ **DOB:** _____ **Date of Injury:** _____
Phone: _____ **Email:** _____
Address: _____ **City, State, Zip:** _____

↓ **FOR OFFICE USE ONLY** ↓

TYPE OF REFERRAL _____ **REFERRED BY** _____
ICD-10: _____ **Diagnosis:** _____
Therapist Initials: ☐
Available to send: ☐ Medical Records (Last office note, operative reports, diagnostic reports, IME)
☐ Job Description ☐ Other: _____
Goals of referral: Establish abilities for: ☐ Return to work ☐ Vocational Placement ☐ WH/WC Optio
Other: _____

CIRCLE PREFERRED CONTACT (PHONE/EMAIL) AND PREFERRED REPORT TRANSMISSION (EMAIL/FAX) FOR ALL CONTACTS ASSOC WITH THE CASE. INCLUDE TITLE (E.G. MD, PA, CM, NCM, ADJ, VC)

Practitioner: _____ **Practice:** _____
Address: _____ **City, State, Zip:** _____
Phone: _____ **Fax:** _____
Email: _____

Case Manager: _____ **Company:** _____
Address: _____ **City, State, Zip:** _____
Phone: _____ **Fax:** _____
Email: _____

Attorney-Clmnt: _____ **Company:** _____
Address: _____ **City, State, Zip:** _____
Phone: _____ **Fax:** _____
Email: _____ **Paralegal:** _____

OTHER ("X"): ☐ Adj. ☐ Atty-Clmnt ☐ Atty-Def ☐ CM ☐ Practioner ☐ TPA ☐
Other: _____ **Company:** _____
Address: _____ **City, State, Zip:** _____
Phone: _____ **Fax:** _____
Email: _____

CONTACT ("X"): ☐ Adj. ☐ Scheduler ☐ Contact ☐ Rep ☐ Other:
BILLED PARTY: _____ **Contact:** _____
Address: _____ **City, State, Zip:** _____
Phone: _____ **Fax:** _____
Email: _____ **Jurisdiction:** _____

FOR "CLAIM #" ("X"): ☐ Member # ☐ Claim # ☐ ID # ☐ Policy #
FOR "REFERRAL #" ("X"): ☐ Group # ☐ Referral # ☐ Case # ☐ Auth # ☐ Order #

CLAIM NUMBER: _____ **REFERRAL NUMBER:** _____
AUTH'D VISITS: _____ **AUTH EXP:** _____

Policy Holder's Name (other than self): _____ **Relationship to Policy Holder:** _____
Policy Holder's Address (if different than above): **Address:** _____
Policy Holder's Date of Birth: _____ **City, State, Zip:** _____
Has a staff member explained your benefits to you? Yes ☐ No ☐ NA

Employment Information (at the time of injury):
Employer: _____ **Position:** _____
Contact: _____ **Phone:** _____

Service: _____ **Scheduled Appt:** _____ @ _____
Date of Referral: _____ **Date of Revision:** _____