Print Form

REQUEST FOR SERVICE

Advocase, LLC
P.O. Box 1287
Clifton Park, NY 12065
www.advocase.com

DATE

Please type in your information in the blank areas.

CLAIMANT/PATIENT NAME	REFERRED BY (NAME) PHONE
ADDRESS	COMPANY/AGENCY
CITY STATE ZIP	ADDRESS
TELEPHONE NUMBER	CITY STATE ZIP
DOI / DATE OF BIRTH	INSURANCE COVERAGE (Check one)
CLAIM NO. / SOCIAL SECURITY NO.	◯ W.C. ◯ LIABILITY ◯ AUTO NO-FAULT ◯ STD/LTD ◯ PERSONAL INJURY ◯ PLAINTIFF ATTORNEY ◯ OTHER

INITIAL TREATMENT (DOCTOR/HOSPITAL NAME/ADDRESS/PHONE)

DIAGNOSIS	ICD.9

CURRENT TREATING DOCTOR/HOSPITAL (NAME/ADDRESS/PHONE)

CLAIMANT'S ATTORNEY (NAME/ADDRESS/PHONE)

GUARDIAN/POWER OF ATTORNEY
N/A

PHONE	RELATIONSHIP

OCCUPATION	AWW	BENEFIT LEVEL	DATE DISABLED
EMPLOYER NAME		PHONE	CONTACT PERSON

EMPLOYER ADDRESS

MEDICAL MANAGEMENT SERVICES:
(check all that apply)

- ☐ EARLY INTERVENTION
- ☐ TELEPHONIC NURSE CASE MANAGMENT
- ☐ ON-SITE NURSE CASE MANAGMENT
- ☐ ON-SITE TASK (LIMITED) NCM ASSIGNMENT
- ☐ ADR
- ☐ NURSE FILE REVIEW
- ☐ PHYSICAN FILE REVIEW
- ☐ MEDICAL "DIRECTION"

COST CONTAINMENT INITIATIVES:

- ◯ RETROSPECTIVE COST ANALYSIS
- ◯ COST PROJECTION
- ◯ CONCURRENT REVIEW
- ◯ MEDICARE OFFSET ANALYSIS
- ◯ PROSPECTIVE FEE NEGOTIATION
- ◯ LIFE CARE PLANNING

SPECIAL INSTRUCTIONS/REASON FOR ASSIGNMENT:

Form prepared by:	**File assigned to NCM:**	**Nurse Assigned by:**