One Heritage Place
Suite 250
Southgate, Michigan 48195
Phone **877.367.8770**
Secure Fax **734.758.0215**
www.expedientmedstaff.com

Request For Case Management Service

DATE OF REFERRAL ______________________________

CLIENT / PATIENT NAME			REFERRED BY (NAME)		
CLAIM NO.	DATE OF INJURY		COMPANY OR AGENCY		
ADDRESS			ADDRESS		PHONE
CITY	STATE	ZIP	CITY	STATE	ZIP
PHONE	DATE OF BIRTH		E-MAIL ADDRESS	FAX#	
SOCIAL SECURITY NO.			INSURANCE COVERAGE ☐ AUTO ☐ W.C. ☐ LONG-TERM ☐ OTHER		

OCCUPATION / JOB TITLE	WAGE $	BENEFIT LEVEL $	DATE OF LOSS
EMPLOYER NAME		PHONE	CONTACT PERSON
EMPLOYER ADDRESS			
DOCTOR(S) HOSPITAL (NAME / ADDRESS / PHONE)			
DIAGNOSIS (DATE)			
CLAIMANT'S ATTORNEY (NAME / ADDRESS / PHONE)			

SPECIAL INSTRUCTIONS / REASON FOR ASSIGNMENT

FILE NO.	DATE RECEIVED	CASE MANAGER NAME / NO.
PERSON COMPLETING RFS FORM	CUSTOMER NO.	