ENCOMPASS
WORKERS' COMP SOLUTIONS

NURSE CASE MANAGEMENT REFERRAL FORM

Check a referral type below:

☐ Full Field Nurse Case Management	☐ Field Task Assignment	☐ Telephonic Nurse Case Management

Is the case litigated? ☐ Yes *(if yes, please complete applicant attorney info below)* ☐ No

INJURED / ILL PERSON:				TPA:		
ADDRESS:				CLAIMS ADJUSTER:		
CITY		STATE:	ZIP:	ADDRESS:		
PHONE:		CLAIM #:		CITY:	STATE:	ZIP:
DOI:	DOH:	DATE OF BIRTH:		PHONE:	FAX:	
DEPARTMENT:		JOB TITLE:		E-MAIL:		
WCIS/JCN #:				EMPLOYER NAME:		
DIAGNOSIS:				APPLICANT ATTORNEY – ATTORNEY NAME		
PRIMARY TREATING PHYSICIAN:				APPLICANT ATTORNEY – FIRM NAME:		
ADDRESS:				ADDRESS:		
CITY:		STATE:	ZIP:	CITY:	STATE:	ZIP:
PHONE:		FAX:		PHONE:	FAX:	

Adjuster Comments/Reason for Referral:

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