AURORA
Case Management

Case Referral Form

Please complete the information below and fax to (877) 791-7837 Questions? Call (410) 365-1725.

Services Requested:
(Check all that apply)

☐ Vocational Rehabilitation
☐ Medical Management
☐ Interpretation - Language: _____
☐ Other (*Please provide additional information in the Comments section)*

Contact Preference: ☐ Phone ☐ Email ☐ Both

Insurance Carrier/Adjuster Information

Your Name *(First Last)*:	
Your Title:	
Company Name:	
Address:	
City, State, Zip:	
Phone Number:	
Fax Number:	
Email Address:	
Claim Number:	

Claimant Information

Name *(First M.I. Last)*:	
Address:	
City, State, Zip:	
Phone Number:	
Email:	
Gender:	
Date of Birth:	
Social Security Number:	
Occupation:	
DOA:	
Injury State:	
State Claim Number:	
Diagnosis:	
Avg. Weekly Wage / Benefit Rate:	

Employer Information

Employer:

Address:

City, State, Zip:

Contact Name *(First Last)*:

Phone Number:

Email Address:

Authorized Physicians

Treatment Physician's Name:

Address

City, State, Zip:

Phone Number:

Fax Number:

Independent Medical Examiner's Name:

Address:

City, State, Zip:

Phone Number:

Fax Number:

Attorney Information

Attorney's Name:

Address:

City, State, Zip:

Phone Number:

Fax Number:

Comments/Special Instructions/Additional Information:

Thank you for taking the time to complete this form. Please fax to (877) 791-7837