P.O. Box 10220, Santa Ana, CA 92711-0220
HOTLINE (855) 626-7827 ▪ Fax (562) 506-0355
Email: tmc.casemgmt@tristargroup.net

REQUEST FOR SERVICE

DATE: _____

Branch/Adjusting Location: _____

Adjuster Name: _____
Adjuster Email _____
Adjuster Phone and Fax _____

Employer Name: _____
Employer Contact: _____
Address: _____
Phone: _____

CLAIMANT INFORMATION:

Claim Number: _____
Claimant Name: _____
Claimant Address: _____

Daytime Phone #: _____
Social Security #: _____
Occupation/Job Title: _____
Date of Birth: _____
Date of Injury: _____
Diagnosis: _____
Secondary Diagnosis: _____
Injury Description (MOI):
(How injury occurred) _____
Treatment already rendered: _____
Body Parts Accepted: _____
Include any diagnostic results, First Report, & JD, if TTD or restrictions. reports, P&S (if MMI)

PHYSICIAN INFORMATION:

Treatment Request:
Treating Physician/Hospital: _____
Address: _____

Contact Person (if known): _____
Phone: _____
Fax: _____

STATE JURISDICTION

ATTORNEY INFORMATION:

Applicant Attorney: _____
Address: _____

Phone and Fax: _____

Defense Attorney: _____
Address: _____
Phone: _____
Fax: _____

☐ Early Intervention

☐ Utilization Review

☐ Utilization Review with Telephonic Case Management task

☐ Telephonic Case Management

☐ Field Case Management
☐ Field Case Management- TASK

☐ Medication Management

☐ Peer Review

***** Mandatory Field for UR*****

Treatment Requested: _____

Date Received Written Request for Treatment _____

Physician Requesting Treatment: _____

Body Part(s):

Special Instructions/Reason for Assignment/Objectives to CM (be as specific as possible):

TMC Office Use Only

TMC File No:	Date:	Case Manager Name: