



REQUEST FOR SERVICE

Please include as much information as possible when filling out the form below. Fax it to us at 1-616-363-5334. The assigned Case Manager will call you within 24 hours to discuss this case.

MAKE A SERVICE REFERRAL: For your convenience you can also make a referral to Starr and Associates via the following methods:

- By calling our main office @ 616-363-4500
- By emailing referral@starrandassociates.net

If you are referring a Stokes Evaluation please include the following information with the referral.

1. Recent medical records with all physical/psychological restrictions
2. Form 105 if available
3. Vocational records (resume, job application, job description)
4. Wage records from the last employer.
5. Criminal records, if any

Service Type:

Medical Case Management	_____	Vocational Case Management	_____
Medicare Set-Aside	_____	Ergonomic Assessment	_____
Stokes Evaluation (see above)	_____	TSA	_____
Medical Cost Projection	_____	Life Care Plan	_____
Medical Bill Review	_____	MCCA Support	_____
Social Security Disability Assistance	_____		_____

Claimant Information

Claim Number: _____

Date of Injury: _____

Social Security #: _____

Birth Date: Month: ____ Day: ____ Year: ____

Full Name (print): _____

Address: _____

City _____ State _____ Zip _____

Phone: _____

Cell Phone: _____

Employer Information

Employer _____

Job Title: _____

Contact Name: _____

Contact Phone: _____

Address: _____

City _____ State _____ Zip _____



Insurance Information

Insurance Carrier/TPA: _____

Name of Claim Representative:

Email: _____

Phone: _____

Address: _____

City _____ State _____ Zip _____

Claim Type: Workers Comp _____
Auto No-Fault _____
Other _____

Treating Physician:

Address of Treating Physician:

City _____ State _____ Zip _____

Diagnosis:

Surgery Date (if applicable):
Month: _____ Day: _____ Year: _____

Attorney Information

Attorney Type: Defense _____ Plaintiff _____

Attorney Name: _____

Phone Number: _____

Address: _____

City _____ State _____ Zip _____

Attorney Type: Defense _____ Plaintiff _____

Attorney Name: _____

Phone Number: _____

Address: _____

City _____ State _____ Zip _____

Additional Comments:

