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 referrals@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: _________________________________

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City ________________ State ______ Zip ________

Additional Comments:

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