EK HEALTH

Ergonomics Referral Form
Please submit via fax at (408) 973-2508 or email: info@ekhealth.com

CARRIER:

☐ **Address Bill to** ☐ **Address Report to**

Adjuster: _____

Phone: _____

E-mail: _____

Company: _____

Address: _____

REFERRAL:

Injured Worker: _____

Phone: _____

DOB: _____

SSN: _____

Claim #: _____

WCAB Board and #: _____

DOI: _____

EMPLOYER:

Employer Name: _____ **Phone:** _____

Employer Contact: _____

AWW (Average Weekly Wage): _____ **Current Job:** _____

HEALTHCARE PROVIDER:

Treating MD: _____ **Phone:** _____ **Fax:** _____

Address: _____

MEDICAL CONDITION/INJURY: _____

_____

ATTORNEYS:

Applicant AAL: _____ **Defense AAL:** _____

Phone: _____ **Phone:** _____

Fax: _____ **Fax:** _____

Address: _____ **Address:** _____

_____ _____

Services:

☐ **Telephonic Case Management**
☐ **Task Assignment**
☐ **Liability Review**
☐ **Field Case Management**
☐ **Ergonomic Assessment**
☐ **Other** _____

By signing below I acknowledge I am authorized to make this referral on behalf of the Carrier and agree to the pricing of the Billing Guidelines and the Referral Terms and Conditions as published on www.ekhealth.com/component/content/article/432

Signature: _____ **Date:** _____