P.O. Box 10220, Santa Ana, CA 92711-0220
HOTLINE 877-2TRISTAR • Fax (714) 571-1810
Pam.guiles@tristargroup.net

REQUEST FOR SERVICE

DATE: ____________________

Referred By: ____________________

Adjuster Name: ____________________

Adjuster Phone: ____________________

Employer Name: ____________________

Employer Contact: ____________________

Address: ____________________

Phone: ____________________

Contact Requested: ____________________

CLAIMANT INFORMATION:

Claim Number: ____________________

Claimant Name: ____________________

Claimant Address: ____________________

Daytime Phone #: ____________________

Social Security #: ____________________

Occupation: ____________________

Date of Birth: ____________________

Date of Injury: ____________________

Date of Lost Time: ____________________

Injury Description: ____________________

PHYSICIAN INFORMATION:

Treating Physician/Hospital: ____________________

Address: ____________________

Phone: ____________________

Fax: ____________________

ATTORNEY INFORMATION:

Claimant Attorney: ____________________

Phone: ____________________

Defense Attorney: ____________________

Phone: ____________________

- ☐ Utilization Review
- ☐ Telephonic Case Management
- ☐ Field Case Management
- ☐ Life Care Estimate

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

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Person Completing Form:	**Management Approval (if applicable):**

TMC Office Use Only

TMC file No:	Case Manager Name:
Referral Type:	Date: