genex
AN ENLYTE COMPANY

FCM Cost Projection/Legal Liability Nurse Review Referral Form

Referral Source Information

Name: **Date of Referral:**

Company Name:

Address:

City: **State:** **Zip:**

Phone: **Fax:** **Email:**

Claimant Information

First Name: **Last Name:**

SSN: **Date of Birth:**

Address:

City: **State:** **Zip:**

Phone:

Claim Information

Claim Number: **Date of Injury:** **Claim Juris:**

Affected Body Part:

Diagnosis:

Employer Information *(only needed for Life Care Plan)*

Employer: **Contact Name:**

Client Job Title: **Average Weekly Wage:** **Weekly Indemnity:**

Physician/Provider Information

Name: **Phone:**

Address:

City: **State:** **Zip:**

Plaintiff Attorney Information

Name: **Phone:**

Address:

City: **State:** **Zip:**

Defense Attorney Information

Name: **Phone:**

Address:

City: **State:** **Zip:**

Special Instructions

Case Type: Please choose **Referral Type:** Please choose

Submit Reset

Call 1.800.245.6402 Email pittsburghfcmreferral@genexservices.com