

Referral Form – Insurer Services Rehabilitation Case Management

Please complete the form and forward with supporting documentation to Banyan Work Health Solutions' Administrative Centre by email at admin@banyanconsultants.com or via fax to our toll free number **1-877-263-0123** or **416-588-9235**

Referral Date: **Nature of Request:** Regular Handling Rush Report (required in ___days)

Referral Source Information:

Referral Source Name: Title:
 Company:
 Address:
 City: Province: Postal Code:
 Telephone (Toll Free): Direct Line: Fax:
 Email:

Claimant Information:

Name: Telephone:
 Address:
 City: Province: Postal Code:
 Email:
 Gender: Male Female Date of Birth: (d/m/y)

Employer Information:

Employer Contact Name: Position/Title:
 Company:
 Address:
 City: Province: Postal Code:
 Telephone (Toll Free): Direct Line: Fax:
 Email:
 Employer not to be contacted

Claim Information:

Claim Number: Policy Number:
 Date of Disability: Occupation: Own Any Any from Outset Regular
 Primary Diagnosis:
 Secondary Diagnosis:
 Occupation:

LTD Change of Definition Date:
 STD Max Benefit Date: Salary Continuance/STD
 Individual
 Other: Claim Approved: Yes No Eligibility Decision: Yes No
 Monthly Benefit Amount: Commensurate Earnings: Other Coverage Amount:

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Interpreter Required: Yes No

Language:

Services for Referral:

Rehabilitation Case Management

Return-to-work planning and implementation

a. In-Person Visit

b. Telephonic Handling

Comprehensive Initial Assessment (Includes Vocational Assessment and recommendations)

a. In-Person Visit

b. Telephonic Handling

Information Gathering Only (No Recommendations/ Vocational Opinion)

a. In-Person Visit

b. Telephonic Handling

Referral Request Specifics: (Claims Issues/Expectations/Desired Outcomes)

**** For additional inquiries or information, please contact our administrative centre at the phone number below or by email at admin@banyanconsultants.com**