

LTD AMERICA NEW CASE FORM

Date: ___/___/___ Case Taken by: _____

Time: ___:___

Called in By: CM ADJ Provider Claimant Lawyer

Called in by Other: _____ Case Assign to: _____ By: _____

Client Information

Client Billing Info (Name of Insurance Carrier): _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone #:(_____)_____-____- Ext: _____ Fax#:(_____)_____-____-

Email Address: _____

Adjusters Information

Adj Name: _____ Phone #: (_____)_____-____- Fax #: (_____)_____-____-

Company: _____ Email: _____

Case Manager Information

CM Name: _____ Phone #: (_____)_____-____- Fax #: (_____)_____-____-

Company: _____ Email: _____

Claimant Information

Apartment House

Claimants Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone #:(_____)_____-____- SS#:_____-____- D.O.B ___/___/___

Type of Injury: _____ Date of Injury: ___/___/___

Employers Name: _____

Contact: _____ Phone #: (_____)_____-____- Claim #: _____

Services Requested

TRANSPORTATION:

Sedan Wheelchair Stretcher
(Does the claimant has his own wheelchair)
Yes No

Height: _____ Weight: _____

Services Requested

LANGUAGE TRANSLATIONS:

Spanish: Creole Other: _____

Notes: _____

APPOINTMENT INFORMATION: PT FCE IME Doctors Surgery Mediation Imaging other

Pick up Location: _____

Destination: _____

Date: ___/___/___ Pick up Time: ___:___ Appt. Time: ___:___ Miles: _____ Return Time: ___:___

Date: ___/___/___ Pick up Time: ___:___ Appt. Time: ___:___ Miles: _____ Return Time: ___:___

Authorization Length: _____