Completed Form can be faxed to: (800) 735-1435
OR
Emailed to: hinesreferral@hinesassoc.com

Prescreen Request for Case Management or Disease Management

Date Submitted: _____ Telephone: _____

REQUESTOR:

Name/Title: _____

Company Name: _____

Address: _____ City, State, Zip: _____

GROUP:

Group Name: _____ Plan/Policy #: _____

Address: _____ City, State, Zip: _____

SELF INSURED? ☐ Yes ☐ No ☐ ERISA *-OR-* ☐ NON-ERISA

CLAIMANT:

Name: _____ DOB: _____

Diagnosis: _____ ICD-10, if available: _____

INSURED:

Name: _____ Relationship to Claimant: _____

Address: _____ City, State, Zip: _____

Insured ID: _____

Telephone #: _____

Claim #: _____ Payment made of: _____

CARRIERS:

Reinsurer Name: _____ MGU Name: _____

Reinsurance/MGU Plan Year: _____ Spec Deductible: _____

Reinsurance Contact Person: _____ Telephone: _____

MGU Contact Person: _____ Telephone: _____

Name of Physician: _____ Telephone: _____

Hospital: _____ City/State: _____

Telephone: _____

SERVICES DESIRED (please check):

☐ Medical Case Management
☐ Behavioral Case Management
☐ Disease Management
☐ Shock Loss/Renewal Reporting
☐ Negotiation/Nurse Review of Medical Necessity
☐ Onsite Evaluation
☐ Nurse Review of Medical Necessity

OTHER INSTRUCTIONS:

_____

_____

_____

_____

_____