REFERRAL FORM

Referral Date:
Best Doctors Case #:

Best Doctors' Referral Procedures for All Programs:

- *Complete Referral Online at:* ***www.bestdoctors.com/bd/referral.php***
- *Submit online, or Fax referral form to:* ***1.877.762.8150***
- *Call our Triage Specialist with questions or assistance with any of the forms at* ***1.866.237.3286***

PROGRAM:

☐ **CatCare Program** ☐ **Legacy Program** ☐ **Ask Best Doctors Program** ☐ **Unknown**

For questions or assistance regarding this form please call our Triage Specialist at 1.866.237.3286.

PERSON WHO PREPARED THIS FORM

Name	
Email	
Phone Number	Fax Number

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth	F ☐ M ☐ Gender
Phone Number	Claim Number	Date of Loss / Injury		
Address (Street & Number; City, State & Zip) *Field will expand as necessary*				

INSURANCE CARRIER INFORMATION

Company

Claims Professional	Email
Billing Address (Street & Number; City, State & Zip) *Field will expand as necessary*	
Phone Number	Fax Number

Supervisor	Email
Phone Number	Fax Number

Is this case either in litigation or expected to be?	Yes ☐	No ☐
Is the medical expert expected to testify?	Yes ☐	No ☐
Can the insurance carrier direct care in the jurisdiction of the claimant?	Yes ☐	No ☐

Reinsurer / Excess Carrier	Claim Number (if available)	State of Jurisdiction

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EMPLOYER INFORMATION

☐ **Not Applicable**

Employer		
Employer Contact	Title	Email
Address (Street & Number; City, State & Zip) *Field will expand as necessary*		
Phone Number	Fax Number	

MECHANISM OF INJURY

Please type in the field, it will expand as necessary

DIAGNOSES IN THIS CLAIM

1
2
3
4
5

LOCATION OF PATIENT

Name of Hospital, Rehab, other
Address (City, State & Zip)

Nurse Case Manager Assigned: ☐ **Yes** ☐ **No**

Medical Records Sent: ☐ **Electronically** ☐ **Hard Copy (overnight to Best Doctors)**

NURSE CASE MANAGER INFORMATION

Company	
Nurse Case Manager	Email
Billing Address (Street & Number; City, State & Zip) *Field will expand as necessary*	
Phone Number	Fax Number

Supervisor	Email
Phone Number	Fax Number

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TREATING PHYSICIAN INFORMATION

Treating Physician	Email
Hospital Mailing Address	
Phone Number	Fax Number

CASE CONCERNS

Please type in the field, it will expand as necessary

LEGACY PROGRAM SPECIFIC:

ATTACHMENTS

☐	Medical records	Number of volumes
☐	Imaging	Total number of images

- **NOTE: PLEASE USE ONLY SINGLE SIDED COPIES WHEN INCLUDING PRINTED DOCUMENTS.**