ENCORE UNLIMITED LLC
"The Tradition of Excellence Continues"

REQUEST FOR SERVICE FORM

Date of Request: _____

SERVICE(S) REQUESTED

☐ Medical/Disability Case Mgmt.	☐ Vocational Services	☐ Liability Review
☐ QRC Services (MN Only)	☐ Ergonomic Assessment	☐ Provider Review
☐ Telephonic Case Management	☐ LOEC	☐ Disability STD / LTD
☐ Limited / Task Assignment	☐ Expert Witness	☐ Other: _____
	☐ Job Analysis	

***-DENOTES REQUIRED FIELDS**

EMPLOYEE

Name*: _____
Address: _____
City*: _____ State: ____ Zip: _____
Home Phone*:_____
Other Phone: _____
Email: _____
DOB: _____ SSN: _____
DOI: _____
Occupation: _____
Avg.Wkly Wage: _____ Hourly Rate: _____
TTD Rate: _____ Hours Per Week: _____

INSURANCE INFORMATION

Name*: _____
Company*: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone*: _____ Ext: _____
Fax: _____
Email: _____
Claim #*: _____
Jurisdiction*: _____

EMPLOYER

Name: _____
Company: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Ext: _____
Fax: _____
Email: _____

PHYSICIAN

Name: _____
Clinic/Hospital: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
Diagnosis: _____
_____
Next Physician Visit: _____

APPLICANT ATTORNEY

Name: _____
Firm: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____

DEFENSE ATTORNEY

Name: _____
Firm: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____

OTHER

Name: _____
Company: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____

NOTES

☐ Specific Case Manager Requested: _____

ADDITIONAL NOTES

General Phone: 800-434-2520 * General Fax: 715-343-1515 * Email: referrals@encoreunlimited.com