apricus
AN ENLYTE COMPANY

Apricus Referral Form

Phone **Fax**

Fields highlighted in red are required.

Referral Information:

Person Making Referral: **Phone:** **Referral Date:**

Choose One: **DC Planner** **Case Manager** **Adjuster** **Other**

Adjuster Name (If Available)**:** **Phone:**

Email Address:

Claim Number: **IW Employer Name:**

Physician Name:

Physician Address:

City: **State:** **ZIP:**

Attorney: **Firm Name:**

Attorney Phone: **Attorney Email:**

Injured Worker Information:

First Name: **Last Name:**

Diagnosis Code:

Phone: **Date of Birth:** **Gender:** **M** **F**

Address:

City: **State:** **ZIP:**

Delivery Address/Contact (If Different From Above)**:**

City: **State:** **ZIP:**

Hospital Discharge and/or Facility Planning

Surgery? **Y** **N** **If Yes, Surgery Date:** **(or) Discharge Date:** **in** **AM** **PM**

Facility Name: **Phone:** **Fax:**

Facility Address:

City: **State:** **Zip:**

Email Address:

Additional Facility Care Management

LTAC Skilled Facility Nursing Home Other

Facility Name: Phone: Fax:

Facility Address:

City: State: Zip:

Email Address:

Services Requested

Weight: lbs. Height: Feet Inches

Durable Medical Equipment	Orthotics & Prosthetics	Respiratory Services
Home Health Care	Hospital Discharge Planning	Electrical Stimulation Devices
Diagnostic/Imaging Services	Home/Vehicle Modifications	TENS Supplies
Medical Transportation	Hearing Aids	Bone Growth Stimulation
Interpretation/Translation	Mobility Devices	Facility Care Management
Catastrophic Care	Medical Supplies	Physical Medicine

Submit Reset

After clicking Submit, an email will open where you can attach prescriptions and any additional information or documentation to support this request.