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

Submit Reset

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