apricus
AN ENLYTE COMPANY

# Apricus Referral Form

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:** **Payor 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 Therapy
- 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.