SIERRA HEALTH-CARE OPTIONS, INC.
SIERRA NEVADA ADMINISTRATORS, INC

MEDICAL MANAGEMENT/MEDICAL DIRECTOR REFERRAL FORM

PLEASE FAX COMPLETED FORM TO: (702) 932-7707

CLIENT: _____

REASON FOR REFERRAL: _____

☐**Telephonic Medical Case Management Assignment**
☐**Request an Onsite Case Manager be assigned and monitored.**
☐**One Time File Review by Nurse or Medical Director**
☐**Other/Comments:** _____

BASIC INFORMATION NECESSARY:

Insurer/TPA:		**ER:**
Date:	**Claimant:**	**Claim No:**
Examiner:	**Email Address:**	**Phone:**
Date of Knowledge:	**Date of Injury/Loss Date:**	
Accepted Body Part(s):		
Cause:	**Nature:**	

If the case is being referred for Case Management, please include the following information in addition to the above.

Claimant Address: **Phone:**

Primary Treating Physician (PTP):

Name: **Specialty:** **Phone:**

Address:

RECORDS ATTACHED

☐**C3** ☐**C4** ☐**All Medical Records**