Hines

Completed Form can be [Faxed: **(800) 735-1435** or
Emailed: **hinesreferral@hinesassoc.com**

Prescreen Request for Case Management or Disease Management

Date Submitted: _____ Telephone: _____

REQUESTOR:

Name/Title: _____

Company Name: _____

Address: _____ City, State, Zip: _____

GROUP

Group Name: _____ Plan/Policy #: _____

Address: _____ City, State, Zip: _____

SELF INSURED? ☐ Yes ☐ No ☐ ERISA -or- ☐ NON-ERISA

CLAIMANT

Name: _____ DOB: _____

Diagnosis: _____ ICD-10, if available: _____

INSURED:

Name: _____ Relationship to Claimant: _____

Address: _____ City, State, Zip: _____

Insured ID: _____

Telephone #: _____

Claim #: _____ Payment made of: _____

CARRIERS:

Reinsurer Name: _____ MGU Name: _____

Reinsurance/MGU Plan Year: _____ Spec Deductible: _____

Reinsurance Contact Person: _____ Telephone: _____

MGU Contact Person: _____ Telephone: _____

Name of Physician: _____ Telephone: _____

Hospital: _____ City/State: _____

Telephone: _____

SERVICES DESIRED (please check):

- ☐ Medical Case Management
- ☐ Behavioral Case Management
- ☐ Disease Management
- ☐ Shock Loss/Renewal Reporting
- ☐ Negotiation/Nurse Review of Medical Necessity
- ☐ Onsite Evaluation
- ☐ Nurse Review of Medical Necessity

OTHER INSTRUCTIONS:

_____

_____

_____

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