

HLP MEDICAL MGMT. MARKETING

REQUEST FOR PHYSICIAN REFERRAL/APPOINTMENT

A complimentary physician referral service

8940 Corbin Ave, Northridge, Ca 91324 (818) 885-0770 FAX:(818) 885-0771

PLEASE FAX: 1. HLP Referral Sheet 2. WC ClaimForm 3.Application/ClientDemographics

We will notify your office via fax or phone-allow 24 hours if appointment is not urgent-IS APPT

URGENT? Yes No

TYPE OF DOCTOR NEEDED:

Ortho type _____ Neurology Chiropractic Pain Mgmt
 Psych _____ Internal _____
 Other _____

EXISTING PTP? Name: _____ **Phone:** _____

Fax _____

(if applicable)

TYPE OF SERVICE NEEDED: EMG/NCV Study Upper / Lower Functional Capacity Assessment

Date: _____ **Person requesting info:** _____ **Phone** _____ **Fax** _____

Law Office: _____ **Address/ City** _____

Case is: Accepted Denied Service needed: PTP TX QME AME
 CONSULT

MPN: _____ **Employer:** _____

Insurance _____

If Application/ Demographics not faxed please fill in the following information:

Client

Name: _____ **Phone:** _____ **Address:** _____

Injuries: _____ **Location(s)**
needed: _____

Comments _____

Thank you for the opportunity to serve you! Questions? Please call -818-885-0770
(THIS PORTION FOR HLP MARKETING OFFICE ONLY)

Attention: _____ **Appointment:** _____ **Referred**

to: _____

Address: _____

Phone; _____ **Fax** _____

Send Paperwork to : _____

Please note that the above mentioned Attorney's office is referring a client for care. If your office needs additional information, please contact HLP office or the applicable persons requesting information. Thank you!

Comments: _____

FORM FAXED TO ATTY (DATE/TIME): _____ **FORM FAXED TO DOCTOR**
(DATE/TIME): _____