Referral Form

Our Referral Form is a quick and easy way to submit a referral for ancillary products and services. Simply fill in the information below and email the completed form to scheduling@compxmedical.com or fax it to (888) 777-4799.

Please call us at (888) 777-9022 with any urgent service needs or questions. Otherwise, we will contact you within 24 hours of receipt to obtain any additional claim details to process this referral. Fields marked with an asterisk (*) are required.

Claim Type

New Claim Existing Claim Date _____ Rush Request

Referral Source

Your Name* _____

Email* _____

Company Name* _____

Phone Number* _____

Relationship to Claimant Claims Professional Case Manager Other – specify: _____

Claimant Information

Claimant Name* _____

Date of Birth* _____

Phone Number* _____

Street Address* _____

City* _____ State* _____ Zip* _____

Claimant Height _____ Claimant Weight _____ Claimant Language _____

Claim Information

Adjuster Name* _____ Adjuster Email* _____

Claim Number* _____ Adjuster Phone*

Employer Name _____

Insurance Carrier/TPA* _____

Date of Injury* _____

Jurisdiction* _____

Claim Type* Workers' Compensation Auto Other – specify: _____

Physician Name _____ Physician Phone Number _____

RX Attached Yes No Diagnosis Code _____

Services Requested

- Transportation
- Language
- Diagnostic Services
- DME/Medical Supplies
- Prosthetics/Orthotics
- Home Health Services
- Discharge Coordination
- Physical Therapy
- Occupational Therapy/CHT
- Speech Therapy
- FCE
- Air Ambulance
- Audits/Negotiations
- Home/Vehicle
- Modifications
- Concierge Services
- Investigations
- Other:

Comments or Other Services