

University of Michigan REQUEST FOR SERVICE



Work-Connections
University of Michigan
Argus II Bldg
400 S. Fourth Street
Ann Arbor MI 48103-4816



Benefits Office

Wolverine Tower-Low Rise
G405
3003 South State Street
Ann Arbor, MI 48109-1278



39500 High Pointe Blvd
Suite 400
Novi, MI 48376-8023
Phone: 248-348-8200
Toll Free: 800-472-1622

Fax: 248-675-2555
www.manageability.com

DATE OF REFERRAL _____

Employee Name		REFERRED BY/ CONTACT PERSON (NAME)	
CLAIM NO (if applicable)	DATE OF INJURY/DISABILITY	<input type="checkbox"/> BENEFITS OFFICE <input type="checkbox"/> WORK~CONNECTIONS	
EMPLID			
ADDRESS		SEND INVOICE FOR PAYMENT TO: <input type="checkbox"/> BENEFITS OFFICE <input type="checkbox"/> WORK~CONNECTIONS	
CITY	STATE	ZIP	W~C ADJUSTOR (NAME) PHONE FAX#
PHONE	DATE OF BIRTH	TYPE OF CLAIM <input type="checkbox"/> Occ. <input type="checkbox"/> Non-Occ. <input type="checkbox"/> Both	
SOCIAL SECURITY NO.			
OCCUPATION:		WAGE	DATE LAST WORKED:
		\$	
DEPARTMENT NAME		SUPERVISOR NAME:	
COMMENTS		SUPERVISOR PHONE:	
Employee's ATTORNEY (NAME/ADDRESS/PHONE)			
MEDICAL MANAGEMENT & VOCATIONAL REHABILITATION SERVICES REFERRED FOR:		MEDICAL INFORMATION WILL BE:	
<input type="checkbox"/> LTD ADJUDICATION		<input type="checkbox"/> FAXED	
<input type="checkbox"/> NURSE CASE MANAGEMENT/POSSIBLE ADJUDICATION		<input type="checkbox"/> MAILED	
<input type="checkbox"/> VOC REHAB ASSESSMENT		<input type="checkbox"/> PICKED UP _____	
<input type="checkbox"/> VOC REHAB LTD RTW (THERAPEUTIC/REHABILITATIVE)		<input type="checkbox"/> OTHER _____	
<input type="checkbox"/> VOC REHAB FILE REVIEW			
<input type="checkbox"/> NURSE FILE REVIEW			
<input type="checkbox"/> NURSE DISEASE MANAGEMENT			
SPECIAL INSTRUCTIONS/REASON FOR ASSIGNMENT			
FILE NO.	DATE RECEIVED	CASE MANAGER NAME/NO.	
PERSON COMPLETING RFS FORM	CUSTOMER NO.		