PDC
SPAN℠ Referral Form

Referring Company: _____ Date of Referral: _____

Referring Person: _____ Date Needed: _____

Phone # of Referring Person: _____

Please √ the services you are requesting:

☐ File Review

☐ SPAN visit with: ☐ *Insured alone* ☐ *AP alone*
☐ *Insured & AP together* ☐ *Other:*_____

Case Details

Name of Insured: _____

Insured's City/State/Zip: _____

Insured's Phone Number: _____

Claim and/or Policy #: _____

Date of Birth: _____

Reported Impairments and or Diagnoses: _____

Occupation: _____

Benefit amount _____

Date of Disability: _____

Present/Past Treatment Providers: _____

(*please indicate specialty of provider & educational degree*) _____

_____

_____

Other Insurance: _____

Attorney: _____

Special Instructions: _____

_____

_____

PDC
1350 Main Street – STE 1600, Springfield, MA 01103-1641
Fax page to: SPAN Coordinator (413) 747-9376
Call PDC at (800) 463-0095 with any questions
E-mail: SPAN@pdcnetwork.com

For PDC use only

Case Assigned to:_____ Date: _____
SPAN Consultant