



Claim Referral Form, page 1 of 2

Please indicate reason for referral:

Claims Review and Resolution

Care Management

Clinical Support

Screening and Early Detection

Medical Review

Medical Underwriting /
Case Cost Analysis

Name of Organization _____ Date _____

Address _____

Contact Name _____

Contact Numbers _____

Fax _____ Email _____

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Claim Referral Form, page 2 of 2

Group Name _____

Group Number _____ Policy Year _____

Stop-Loss Carrier _____

Specific Deductible _____

Hospital/Institution _____

Hospital/Institution Phone Number _____

Physician Name(s) _____

Physician Phone Number(s) _____

Patient _____ Date of Birth _____

Patient Address _____

Patient Phone Number(s) _____

Patient ID Number(s) _____

Diagnosis _____

Date of Initial Diagnosis _____ Claim Paid to Date _____

TPA Name _____

TPA Address _____

TPA Case Manager Name _____

TPA Case Manager Contact Number _____

Total Billed Charges for This Claim _____

Total Billed Charges from Date of Diagnosis _____

*In addition to the information in the file, please submit as much clinical information as possible.
This includes surgery, chemotherapy, radiation therapy, and pharmacy.*



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