Worker's Compensation Referral Form

Fax Referral Form to: 858-227-9766

Adjuster Name: _____

Adjuster Phone: _____

Insurance Carrier _____

Adjuster E-mail: _____

Employer Name: _____

Claimant Name: _____

Claim Number: _____

Date of Injury: _____

Date of Birth: _____

Physician Name: _____

Physician NPI: _____

Physician Address: _____

Physician Phone: _____

Physician Fax: _____

Practice Name: _____

Millennium will contact you within the next 24-48 hours to complete this request.
If you have any questions please contact the Workers Compensation Department at 877-451-3534