CM Comprehensive Medical
CM Case Management, LLC
344 Grove Street, #51
Jersey City, NJ 07302

888.377.CMCM (2626)
Fax: (201) 413-5209

LCP - Case Intake/Referral Form

Claimant Information

Name ____ Sex ___________

Address ____

City, State _____________________________________Zip ____________

Home Phone _________________________ Cell Phone ________________

Fax ________________________________ Email_____________________

S.S. # _______________________________ D.O.B. __________________

Contact Person (if other than claimant) _______________________________

Phone _____________________________Email______________________

Claimant Attorney (D/P)

Name ______________________________Firm ______________________

Address ____

Phone______________________________ Fax _______________________

Email____

Paralegal/Assistant____

Direct Line ________________________Email _______________________

Insurance Carrier/ TPA/ Self Insured (If Applicable)

Adjuster Name ____

Address ____

Phone ____________________Fax _______________ Email____________

Injury Information

Date of Injury ______________________

Description of Injury ____

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Has Client Had Surgery as a result of injury? Yes_____ No _____Date________

If Yes, surgery type ____

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Pre-Existing Conditions ____

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Claimants Highest Educational Level Achieved _________________________

Employment History

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Additional Information

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If there are any questions concerning this referral or the LCP process, please contact us at 888-377-CMCM (2626) or e-mail Jeanine Fastov at j.fastov@cm2x.com