University of Michigan
REQUEST FOR SERVICE

UNIVERSITY OF MICHIGAN
Work~Connections

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

Human Resources & Affirmative Action
Benefits Office

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

MANAGEABILITY
managed care solutions

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) EMPLID	DATE OF INJURY/DISABILITY	☐ BENEFITS OFFICE ☐ WORK~CONNECTIONS
ADDRESS		***SEND INVOICE FOR PAYMENT TO:*** ☐ ***BENEFITS OFFICE*** ☐ ***WORK~CONNECTIONS***
CITY STATE ZIP		W~C ADJUSTOR (NAME) PHONE FAX#
PHONE	DATE OF BIRTH	TYPE OF CLAIM ☐ Occ. ☐ Non-Occ. ☐ Both
SOCIAL SECURITY NO.		

OCCUPATION:	WAGE $	DATE LAST WORKED:	
		SUPERVISOR NAME:	
DEPARTMENT NAME		SUPERVISOR PHONE:	

COMMENTS

Employee's ATTORNEY (NAME/ADDRESS/PHONE)

MEDICAL MANAGEMENT & VOCATIONAL REHABILITATION SERVICES REFERRED FOR:

- ☐ LTD ADJUDICATION
- ☐ NURSE CASE MANAGEMENT/POSSIBLE ADJUDICATION
- ☐ VOC REHAB ASSESSMENT
- ☐ VOC REHAB LTD RTW (THERAPEUTIC/REHABILITATIVE)
- ☐ VOC REHAB FILE REVIEW
- ☐ NURSE FILE REVIEW
- ☐ NURSE DISEASE MANAGEMENT

MEDICAL INFORMATION WILL BE:

- ☐ FAXED
- ☐ MAILED
- ☐ PICKED UP _____
- ☐ OTHER _____

SPECIAL INSTRUCTIONS/REASON FOR ASSIGNMENT

Invoice to Bonnie Marttila?: Y ☐ N ☐

Other (Name): _____ Y ☐ N ☐

Report to Bonnie Marttila?: Y ☐ N ☐

Other (Name): _____ Y ☐ N ☐

FILE NO.	DATE RECEIVED	CASE MANAGER NAME/NO.
PERSON COMPLETING RFS FORM	CUSTOMER NO.	