

**DISABILITY INTAKE REFERRAL**

Date:

Claimant's Name:

SSN:

Date of Birth:

Phone:

Address:

City, State, Zip:

Disability:

Onset Date:

Referred By:

Phone or Beeper:

Is Claimant in the Hospital? (if so what Room #)

Admission Date:

Discharge Date:

Is Claimant Insured or Self Pay?

Filing for Medicaid? (Date and Time):

Is this a TERI case?

***Claimant's Representative (if unable to assist with own claim)***

***Representative and Relationship to claimant:***

***Phone:***

***Additional Comments:***