



WVU Occupational Medicine
 4 Medical Center Dr. Box 9145
 Morgantown, WV 26506-9145
 Phone 304-293-3693
 Fax 304-293-2629

Please email completed form with medical records to wvuocmed@hsc.wvu.edu

Referring Provider: _____ Contact: _____
 Specialty: _____ Phone: _____ Fax: _____
 Address: _____

Type of Referral:
 One-time Consultation Transfer of Care
 (We **DO NOT** assume care.)

Patient Name: _____ Phone: _____ Date of Birth: _____
 Address: _____

Reason for Referral:

Accepted Diagnosis Codes: _____ **PLEASE SEND ALL MEDICAL RECORDS.**

Billing Information:
 Worker's Compensation Insurance
 Claim #: _____ Insurance ID: _____
 Date of Injury: _____

Carrier Name: _____ Phone: _____ Fax: _____
 Address: _____

Claims Manager: _____ Authorization #: _____

Employer: _____

Employer Address: _____

Employer Contact: _____ Phone: _____ Fax: _____

Signature of Referring Provider: _____ Date: _____

Confidentiality Notice:

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