



USPS / Align Networks Referral Form

Align USPS Dedicated Phone: # 877-422-5446

Align USPS Dedicated Fax: # 904-394-8342

Align Email: referrals@alignnetworks.com

USPS CLAIMANT CASE FILE # \_\_\_\_\_

SERVICE TYPE REQUESTED: \_\_\_\_\_ REQUESTED FREQ/DURATION: \_\_\_\_\_

**Patient Information (demographics)**

|                 |              |                       |  |
|-----------------|--------------|-----------------------|--|
| Last name:      |              | First name:           |  |
| Sex: M/F        | Working: Y/N | Spanish Speaking: Y/N |  |
| DOB:            | SSN:         |                       |  |
| Street Address: |              | Zip Code:             |  |
| City:           | State:       |                       |  |
| Home Ph:        | Work Ph:     | Cell:                 |  |

**Injury Information**

|                    |                       |             |  |
|--------------------|-----------------------|-------------|--|
| Injury Date:       | Injury State:         | Claim #:    |  |
| Injured Body Part: |                       | Side:       |  |
| Diagnosis:         | Surgical: Y/N         | Date of Sx: |  |
| Freq/Dur:          | Special Instructions: |             |  |

**Physical Information**

|          |              |
|----------|--------------|
| MD Name: | Address:     |
| Phone:   | Fax:         |
| RX date: | Next MD apt: |

**Agency Information (If available)**

|                 |
|-----------------|
| Agency Name:    |
| Agency Address: |
| Agency Code:    |

**CM Information (If available)**

|                   |          |
|-------------------|----------|
| Name:             | Company: |
| Physical Address: |          |
| Phone:            | Fax:     |
| Email address:    |          |

***Please include copy of MD RX with this form***