

# Referral Form

## For Insurers and Employers



Please return completed form by email or facsimile.

Email: **referrals@recovre.com.au**

Facsimile: **1300 723 405**

If you have any questions or require further assistance, please call us on **1300 550 276**.

Please  tick boxes as appropriate.

### ATTACHMENTS:

Medical report

Claim form(s)

Medical certificate

Other (please specify):

### Referrer Details

<b>Name:</b>				<b>Title:</b>		
<b>Address:</b>						
	<b>City:</b>		<b>State:</b>		<b>Postcode:</b>	
<b>Postal address:</b>						
<b>Phone:</b>				<b>Facsimile:</b>		
<b>Email:</b>				<b>Date of referral:</b>		
<b>Signature:</b>				<b>Who is paying for the service?</b>	<input type="checkbox"/> Employer	<input type="checkbox"/> Insurer

### Insurer Details

As per referrer details above

Insurer name:

Contact name: Contact title:

Address:

City: State: Postcode:

Postal address:

Phone: Facsimile:

Email:

### Employer Details

As per referrer details above

Industry:

Employer name:

Postal address:

#### 1. RTW Co-ordinator/Supervisor/Contact person

Name: Phone: Facsimile:

Email: Mobile:

#### 2. RTW Co-ordinator/Supervisor/Contact person

Name: Phone: Facsimile:

Email: Mobile:

Additional information:

