MCN Medical Consultants Network

Faxable Scheduling Form
National Operations

1301 5th Avenue, Suite 2900 | Seattle, WA 98101
t: 206.621.9097 | t: 800.636.3926 | f: 206.623.4956 | national@mcn.com

☐ **NE Operations**	☐ **SE Operations**	☐ **Midwest Operations**	☐ **Western Operations**	☐ **SW Operations**
445 Broadhollow Rd., Ste. 336 Melville, NY 11747 T: 800.394.4637 F: 631.454.8522 newyork@mcn.com	14499 N. Dale Mabry Hwy., Ste. 260-S Tampa, FL 33618 T: 800.331.6269 F: 813.968.3104 tampa@mcn.com	1230 E. Diehl Rd., Ste. 302 Naperville, IL 60563 T: 630.620.4550 F: 630.620.2661 chicago@mcn.com	901 Boren Ave. Ste. 1400 Seattle, WA 98101 T: 800.336.6269 F: 206.343.2196 Seattle@mcn.com	13355 Noel Rd, Ste. 1131 Dallas, TX 75240 T: 855.310.4637 F: 972.661.0808 Dallas@mcn.com

Scheduling Specifics

Referral Date: ___________ Due Date: _______________ Date Picked Up: _________	☐ Basic Turn Around Time ☐ Expedited ☐ Priority

Specialty Requested (please mark all that apply)

☐ Chiropractic ☐ Neurological Surgery ☐ Neurology	☐ Occupational Medicine ☐ Orthopedic Surgery ☐ Otolaryngology	☐ PM & R ☐ Psychiatry ☐ Other:___________ _________________

Service Request (please mark all that apply)

☐ IME only ☐ Medical Peer Review ☐ FCE ☐ Nurse analysis	☐ IME with FCE ☐ Pharmacy Review ☐ Radiology review *(X-Ray, MRI, CAT Scan)*	☐ Peer review ☐ Nurse analysis ☐ Line-by-line bill audit	☐ Peer review w/ verbal report only ☐ Pharmacy Review ☐ Radiology review *(X-ray/MRI/CAT Scan)*

Patient/Claimant Information

Patient Name	Gender M ☐ F ☐	Claim/Control Number		Employer
Patient Address		Diagnosis		Employer Phone
Patient City/State/Zip		Date of Injury/Date of Disability		Attending/Treating Physician
Home Phone		Attorney	Phone Number	Attending/Treating Physician Address
Social Security Number	Date of Birth	Attorney Address		Attending/Treating Physician Phone
State Claim Filed In		Attorney City/State/Zip		

Client/Contact Information

Name	Title	
Address	Phone Number	Fax Number
City/State/Zip	Email Address	

Special Instructions

____

____

____

For MCN use: ______________________

Date received: ______________________

Date scheduled: ______________________

Scheduled by: ______________________