

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

220 French Landing Dr.

Nashville, Tennessee 37243-1002



CASE MANAGEMENT NOTIFICATION

EMPLOYEE INFORMATION

State File # _____ Date of Injury _____ Social Security # _____
Claimant _____

EMPLOYER INFORMATION

FEIN: _____ Employer: _____
Street: _____ City: _____ State: _____ Zip: _____

INSURER INFORMATION

Insurer: _____
Insurer Address: _____
Insurer Claim #: _____ Policy Number: _____

CASE MANAGEMENT ELECTION

_____ Proof of notification has been provided to employee that employer has elected to use
Case Management.

PROVIDER INFORMATION

Case Management Provider _____ I.D. # _____
Case Management Provider Address _____

CASE MANAGER INFORMATION

Case Management Provider Phone # _____
Date Case Manager received referral _____
Date Face to Face Meeting took place between CM and Employee

Case Manager _____ TN CM Registration # _____
Comments _____
