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REQUEST FOR SERVICE FORM

Account Information:

Company: _____
Contact: _____
Address: _____

City/State: _____
Telephone: _____
Fax: _____
E-Mail: _____

Client Information:

Claimant: _____
Claim #: _____
Social Security #: _____
Address: _____

City/State: _____
Telephone: _____
Date of Birth: _____ Sex: Male Female
Occupation: _____
DOI: _____ Diagnosis: _____
Vocational: Weekly Benefit _____ Weekly wage _____

Employer Information:

Employer: _____
Contact: _____
Address: _____

City/State: _____
Telephone: _____
Fax: _____

Treating Physician:

Name: _____
Address: _____

City/State: _____
Contact: _____
Telephone: _____
Fax: _____

Attorney:

Plaintiff Attorney: _____
Address: _____

City/State: _____
Telephone: _____

Defense Attorney: _____
Address: _____

City/State: _____
Telephone: _____

Type of Claim: (Check all that apply)

Workers' Comp Auto Liability LTD/STD

Other: _____

Products & Services: (Check all that apply)

Case Management: Telephonic Medical On-site Catastrophic
 Vocational Services
 Medical Bill Review/Repricing
 Peer Review/IME
 Occupational Health Services
 Interpreting/Translating

Special Instructions:

For Internal Use Only

Case Manager: _____

Date Received: _____