

**Claimant Name:**

Claimant DOB:

Last 4 of Claimant SS# :

Claimant Address:

Date of Injury:

**Employer:**

Employer Address:

**Insurance Company (if applicable):**

Policy Number:

Claim Number:

Insurance Address for Billing:

Adjuster:

Adjuster E-Mail:

Is a HCFA required for billing? Y N

**Point of Contact for IME:**

Court File#:

Expedited: Y N

**Accepted Body Parts:**

**Denied Body Parts:**

What Issues to address:

**Additional notes (if any):**

We will contact you shortly to set up an appointment.

\*\*\*Thank you for choosing us\*\*\*