

EMAIL:
Cell:

PHONE:
Fax to:

Date of Request:	<input type="checkbox"/> Rush
Service Requested	
<input type="checkbox"/> Impairment Rating Audit/review	<input type="checkbox"/> Custom request / IME:
<input type="checkbox"/> Estimated Impairment Rating (no IR included)	<input type="checkbox"/> Mental and Behavioral Disorders Evaluation
<input type="checkbox"/> AMA Guides 4 th 5 th 6 th	<input type="checkbox"/> Medical File Review
Insurance	
<input type="checkbox"/> Workers' Comp <input type="checkbox"/> Disability <input type="checkbox"/> Liability <input type="checkbox"/> Auto	

Requesting Party			
Customer			
Company			
Address:			
City:			
State:			
Phone:			
Fax:			
Email:			

Claim Information	
First Name:	
Last Name:	
Claim Number:	
Date of Birth:	
Date of Injury	
Claim Jurisdiction:	
Address:	
City:	
State/ Zip Code	
Employer:	
Occupation:	
Job Function:	

Email receipt of referral sent within 48 hours

Medical Audit: Check Request
<input type="checkbox"/> Prognosis (estimated RTW)
<input type="checkbox"/> Provide an MMI Date
<input type="checkbox"/> Causal Relationship of Injury
<input type="checkbox"/> Verify Diagnosis
<input type="checkbox"/> Identify Restrictions of ADL (activities of daily living)
<input type="checkbox"/> Apportionment (what % of injury is job-related)

Injury Information	
Compensable Body Part(s):	
Diagnosis:	
Diagnosis:	
Diagnosis:	
Additional Comments	