# SERVICE REQUEST INFORMATION

## CLAIMS ADJUSTER

Name: _____

Title: **Claims Adjuster**

Company Name: _____

Address: _____

City: _____ St:____ Zip:_____

Telephone: _____

Fax: _____

Email Address: _____

## CLAIMANT INFORMATION

Name: _____

Address: _____

City: _____ St: ____ Zip: _____

Telephone: _____

Cell: _____

Birthday: _____ SS# _____

Occupation: _____

Avg. Hourly Wage/Benefit Rate: $_____

Has claimant been advised of our role? ☐ ☐

## PLAINTIFF ATTORNEY

Name: _____

Address: _____

City: _____ St:____ Zip: _____

Telephone: _____

Fax: _____

## PHYSICAL THERAPIST

Practice Name: _____

Name: _____

Telephone: _____

## DEFENSE ATTORNEY

Name: _____

Address: _____

City: _____ St:_____ Zip: _____

Telephone: _____

Fax**:** _____

D.O.I.: _____

Claim File No**.** _____

## EMPLOYER

Date of Hire**:** _____

Company Name: _____

Address: _____

City: _____ St:____ Zip: _____

Contact Name: _____

Title: _____

Telephone: _____

Fax: _____

## TREATING PHYSICIAN

Name**:** _____

Specialty: _____

Address: _____

City:_____ St: ____ Zip:_____

Telephone**:** _____

Fax: _____

Injury or Disability: _____

_____

Notes: _____

_____

**INTEROFFICE USE ONLY**

Referral Date:
Our File No.:
Consultant:

Special Handling:
Clerical Allowed**:**
Type of Claim: