

Request is for: <i>(check all that apply)</i>	RECORDS	BILLING	FILMS/X-RAYS/MRI
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CLIENT INFORMATION

ATTORNEY _____

FIRM _____

CONTACT _____

ADDRESS _____

PHONE _____

E-MAIL _____

CASE INFORMATION

PATIENT/EMPLOYEE NAME _____

BIRTH DATE _____

SOCIAL SECURITY NO. _____

CASE NAME _____

FILE/CLAIM NUMBER _____

CAUSE NUMBER _____

DATE OF LOSS _____

ADJUSTER NAME _____

ADDRESS _____

BILL ADJUSTER BILL ATTORNEY

Check if Rush

_____ **Date needed AND reason for rush**

PREFERENCES *(Check applicable fields)*

<input type="checkbox"/> 1 Copy of Records	<input type="checkbox"/> 2 Copies of Records**	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> Records Numbered*	<input type="checkbox"/> Records Not Numbered	_____
<input type="checkbox"/> Records Stapled	<input type="checkbox"/> Records 2-Hole Punched (Top)	_____
<input type="checkbox"/> Electronic/PDF format	<input type="checkbox"/> Records 3-Hole Punched (Side)	

*Additional cost for numbering

**Additional cost for 2nd copy of records

OPPOSING COUNSEL INFORMATION

ATTORNEY _____
FIRM _____
CONTACT _____
ADDRESS _____

PHONE _____
E-MAIL _____

Records requested from the following facilities:

*Name, address, telephone & fax, if available. All records requested **unless** date range specified below.*
