

<b>Date of Request:</b>	<input type="checkbox"/> <b>Rush</b>
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Service Requested	
<input type="checkbox"/> <b>Impairment Rating Review (AMA Compliant Review)</b>	<input type="checkbox"/> <b>Complex – Multiple Report Review</b>
<input type="checkbox"/> <b>Deposition Review or Questions</b>	<input type="checkbox"/> <b>CA Pre 1997 to 2005 Review (Old Rating)</b>
<input type="checkbox"/> <b>Complex Medical Review</b>	<input type="checkbox"/> <b>CA Rapid Rating (PDR)</b>
<input type="checkbox"/> <b>Other:</b>	

**Benefit Exposure if Submitted Impairment Rating is Accepted: \$**

Requesting Party			
<b>Name:</b>			
<b>Company:</b>			
<b>Address:</b>			
<b>City:</b>			
<b>State:</b>		<b>Zip:</b>	
<b>Phone:</b>		<b>Ext:</b>	
<b>Fax:</b>			
<b>Email:</b>			

Claim Information		
<b>First Name:</b>		
<b>Last Name:</b>		
<b>Claim Number:</b>		
<b>DOI:</b>		
<b>DOB:</b>		
<b>Claim Jurisdiction:</b>		
<b>Employer:</b>		
<b>Occupation:</b>		
<b>Job Function:</b>		
<b>Defense Lawyer:</b>		
<b>Address:</b>		
<b>City:</b>		
<b>State:</b>		<b>Zip:</b>
<b>Do you want our report sent to Defense Lawyer?</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	

**Send Bill to Requesting Party?**     **Yes**     **No**  
**If No, Fill in Information Below**

Billing Information			
<b>Recipient:</b>			
<b>Address:</b>			
<b>City:</b>			
<b>State:</b>		<b>Zip:</b>	
<b>Fax:</b>			
<b>Email:</b>			

Injury Information	
<b>Rating Physician:</b>	
<b>Compensable Body Part(s):</b>	
<b>Diagnosis:</b>	
<b>ICD9 Code:</b>	
<b>ICD9 Code:</b>	
<b>ICD9 Code:</b>	

For CA Disability Ratings	
<b>Number of Employees:</b>	
<b>Average Weekly Wage</b>	
<b>Was Job Offered?</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
<b>Date of Offer:</b>	

Comments and/or Special Instructions