CLAIMS BUREAU USA

ASSIGNMENT ORDER FORM

800-651-0460 fax : 800-651-0496

www.claimsbureau.com

CUSTOMER NAME : _____ COMPANY : _____

IF NEW CUSTOMER, INCLUDE ADDRESS : _____

_____

EMAIL : _____ PHONE : _____

CLAIM # : _____ TYPE OF CLAIM : ☐ WORKERS COMP ☐ LIABILITY ☐ DISABILITY ☐ AUTO

CLAIMANT INFORMATION

NAME : _____ SEX : _____ HEIGHT : _____ WEIGHT : _____

LAST KNOWN ADDRESS : _____

SECONDARY ADDRESS : _____

PRIMARY PHONE : _____ SECONDARY PHONE : _____

AGE : _____ DOB : _____ SSN : _____ RACE : _____ BUILD : _____

HAIR COLOR : _____ OTHER PHYSICAL FEATURES : _____

MARITAL STATUS : _____ SPOUSE'S NAME: _____ # DEPENDENTS : _____

DRIVER'S LIC. # : _____ ST : __ VEHICLES : _____

ACCIDENT/INJURY INFORMATION

DATE OF INJURY/ACCIDENT : _____ TYPE OF INJURY(IES) : _____

JOB DESCRIPTION : _____

ACCIDENT DESCRIPTION : _____

IS SUBJECT IN PHYSICAL THERAPY? : _____ RECEIVING BENEFITS? : _____ AMT : _____

INSURED INFORMATION

INSD COMPANY : _____ CONTACT : _____ PHONE : _____

ADDRESS: _____

ATTORNEY INFORMATION IS SUBJECT REPRESENTED : _____

WORK TO BE COMPLETED

SERVICE(S) DESIRED : _____ DATE DUE : _____

BUDGET : $_____ **OR** # DAYS : _____

DOES SUBJECT HAVE AN APPOINTMENT? : _____ DATE : _____ TIME : _____

LOCATION : _____ PHYSICIAN : _____

SPECIAL INSTRUCTIONS : _____

_____

_____

_____

PACKAGING - *choose all that apply-*

☐ EMAIL WITH VIDEO LINK

☐ MAIL HARD COPY WITH : ☐ CD ☐ VHS **OR** ☐ DVD *-please choose one-*