LEGAL FORCE

Legal Force LLC Request Form email: Service@LegalForceDirect.com
Phone: 323.645.0675 Fax: 253.390.9605

Attorney Name: Bar Number:

Case Number: Need By Date if RUSH:

Attorney Email:

Attorney Phone:

Court Location:

Applicant Name: AKA:

ADJ : SSN: DOB: DOI:

Insurance Carrier: Phone:

Request Records: (Please Check One) : Yes No
Insurance Address: Street:
City: State: Zip:

Defense Attorney: Phone:
Defense Address: Street:
City: State: Zip:

CLAIM NUMBER:
Adjuster Name:

Adjuster Email:

Adjuster Phone:

Employer: Phone:

Request Records: (Please Check One): Yes No
Employer Address: Street:
City: State: Zip:

PLEASE LIST ALL MEDICAL RECORDS NEEDED & NAME OF FACILITIES/DOCTOR, PHONE & ADDRESS.

1. Facilities Name: Phone:
Doctor:
Address: Street:
City: State: Zip:

2. Facilities Name: Phone:
Doctor:
Address: Street:
City: State: Zip:

3. Facilities Name: Phone:
Doctor:
Address: Street:
City: State: Zip:

PLEASE LIST ANY SPECIAL INSTRUCTIONS: Example specify if IMR or 2ND sets to QME & address below:

If out of state or no case number is available please attach attorney signed authorization.