Legal Force LLC Request Form email: Service@LegalForceDirect.com
Phone: 323.483.1275 Fax: 1.310.943.1908

Attorney Name:

Attorney Email:

APPLICANT NAME:

ADJ: SSN: DOB: DOI: -

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Insurance Carrier: PHONE

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

CLAIM NUMBER:
Adjuster Name:

Adjuster Email:

Adjuster Phone: EXT: FAX:

Employer: Phone:

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

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

1. Facilities Name: Phone:
Doctor:
Address:Street/City/ST/Zip:
Fax: Date of Service:

2. Facilities Name: Phone:
Doctor:
Address:Street/City/ST/Zip:
Fax: Date of Service:

3. Facilities Name: Phone:
Doctor:
Address:Street/City/ST/Zip:
Fax: Date of Service:

LIST EXTRA MEDICAL RECORDS OR ANY SPECIAL INSTRUCTIONS: Example specify if IMR or 2ND sets to QME address: