



LEGAL FORCE

Legal Force LLC

Request Form

email: [Service@LegalForceDirect.com](mailto:Service@LegalForceDirect.com)

Phone: 310.961.2740

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 Circle One):    Yes / No			
Insurance Address: Street:			
City:		State:	Zip:
Defense Attorney:		Phone: (     )     -	
Defense Address: Street:			
City:		State:	Zip:
<div>CLAIM NUMBER:</div> <div>Adjuster Name:</div> <div>Adjuster Email:</div> <div>Adjuster Phone: (     )     -</div>			
Employer:		Phone: (     )     -	
Request Records: (Please Circle 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 2 <sup>ND</sup> sets to QME & address below:			
If out of state or no case number is available please attach attorney signed authorization.			