



Legal Force LLC      Request Form  
Phone: 323.483.1275      Fax: 1.310.943.1908

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

Attorney Name:

Attorney Address:

APPLICANT NAME:

ADJ:

SSN:

DOB

DOI:

-

Insurance Carrier:

PHONE

Request Records: (Please Check One) :    Yes   /    No

Insurance Address:

Street/City/State/Zip:

CLAIM NUMBER:

Adjuster Name:

Adjuster Phone/Ext:

Adjuster Fax:

Employer:

Phone:

Request Records: (Please Check One):    Yes   /    No

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

1. Facilities Name:

Phone:

Doctor:

Fax:

Address:Street/City/ST/Zip:

2. Facilities Name:

Phone:

Doctor:

Fax:

Address:Street/City/ST/Zip:

3. Facilities Name:

Phone:

Doctor:

Fax:

Address:Street/City/ST/Zip:

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