

EXPERT REVIEW FORM

Client Name:	<input type="text"/>	Phone#	<input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/>
Address	<input type="text"/>	Fax#	<input type="text"/> - <input type="text"/> - <input type="text"/>
City	<input type="text"/>	State	<input type="text"/> <input type="button" value="v"/>
Email Address	<input type="text"/>	Zip	<input type="text"/>

Plaintiff Attorney Name:	<input type="text"/>	Phone#	<input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/>
Address	<input type="text"/>	Fax#	<input type="text"/> - <input type="text"/> - <input type="text"/>
City	<input type="text"/>	State	<input type="text"/> <input type="button" value="v"/>
Email Address	<input type="text"/>	Zip	<input type="text"/>

Claimant:	<input type="text"/>	Phone#	<input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/>
Address	<input type="text"/>	D.O.B	<input type="text"/> / <input type="text"/> / <input type="text"/>
City	<input type="text"/>	State	<input type="text"/> <input type="button" value="v"/>
		Zip	<input type="text"/>

Please Address:

- | | |
|---|--|
| <input type="checkbox"/> DIAGNOSIS | <input type="checkbox"/> PRIOR HISTORY |
| <input type="checkbox"/> LENGTH OF TOTAL/PARTIAL DISABILITY | <input type="checkbox"/> CAUSAL RELATIONSHIP |
| <input type="checkbox"/> REASONABLENESS OF TREATMENT | <input type="checkbox"/> WORK STATUS |
| <input type="checkbox"/> REASONABLENESS OF FEES | <input type="checkbox"/> MEDICAL END RESULT |
| <input type="checkbox"/> PERMANENCY EXPECTED | <input type="checkbox"/> MAXIMUM MEDICAL IMPROVEMENT |
| <input type="checkbox"/> CURRENT MEDICAL STATUS | <input type="checkbox"/> PROGNOSIS |

Type of Review	<input type="text"/>
Type of Claim	<input type="text"/>
DOI	<input type="text"/>
Insured	<input type="text"/>
Claim#	<input type="text"/>

Special Instructions:

- | |
|---|
| <input type="checkbox"/> PLEASE RUSH REPORT |
| <input type="checkbox"/> WILL FORWARD FURTHER INFO |
| <input type="checkbox"/> PLEASE REVIEW ATTACHED FILMS |

other

Comments	<input type="text"/>
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