PO Box 330, Exton, PA 19341
Phone: 610.524.1005
Fax: 610.524.1006
info@tqconsultants.net
www.tqconsultants.net

REQUEST FOR SERVICE FORM

Account Information:

Company: ______________________________
Contact: ______________________________
Address: ______________________________
____
____
City/State: ______________________________
Telephone: ______________________________
Fax: ______________________________
E-Mail: ______________________________

Client Information:

Claimant: ______________________________
Claim #: ______________________________
Social Security #:______________________________
Address: ______________________________
____
City/State: ______________________________
Telephone:______________________________
Date of Birth: ____________ Sex: Male❑ Female❑
Occupation: ______________________________
DOI: ___________Diagnosis:________________
Vocational: Weekly Benefit ______Weekly wage ______

Employer Information:

Employer: ______________________________
Contact: ______________________________
Address: ______________________________
____
City/State: ______________________________
Telephone: ______________________________
Fax: ______________________________

Treating Physician:

Name: ______________________________
Address: ______________________________
____
City/State: ______________________________
Contact: ______________________________
Telephone: ______________________________
Fax: ______________________________

Attorney:

Plaintiff Attorney: __________________________
Address: ______________________________
____
City/State: ______________________________
Telephone: ______________________________

Defense Attorney: __________________________
Address: ______________________________
____
City/State: ______________________________
Telephone: ______________________________

Type of Claim: *(Check all that apply)*

❑ Workers' Comp ❑ Auto Liability ❑ LTD/STD Other: ______________________________

Products & Services: *(Check all that apply)*

Case Management: ❑ Telephonic ❑ Medical On-site ❑ Catastrophic
- ❑ Vocational Services
- ❑ Medical Bill Review/Repricing
- ❑ Peer Review/IME
- ❑ Occupational Health Services
- ❑ Interpreting/Translating

Special Instructions:

____
____
____

For Internal Use Only

Case Manager:______________________________ Date Received: ______________________________