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