



# CLAIMS BUREAU USA

ASSIGNMENT ORDER FORM  
800-651-0460 fax : 800-651-0496  
www.claimsbureau.com

CUSTOMER NAME : \_\_\_\_\_ COMPANY : \_\_\_\_\_

IF NEW CUSTOMER, INCLUDE ADDRESS : \_\_\_\_\_

EMAIL : \_\_\_\_\_ PHONE : \_\_\_\_\_

CLAIM # : \_\_\_\_\_ TYPE OF CLAIM :  WORKERS COMP  LIABILITY  DISABILITY  AUTO

## CLAIMANT INFORMATION

NAME : \_\_\_\_\_ SEX : \_\_\_\_\_ HEIGHT : \_\_\_\_\_ WEIGHT : \_\_\_\_\_

LAST KNOWN ADDRESS : \_\_\_\_\_

SECONDARY ADDRESS : \_\_\_\_\_

PRIMARY PHONE : \_\_\_\_\_ SECONDARY PHONE : \_\_\_\_\_

AGE : \_\_\_\_\_ DOB : \_\_\_\_\_ SSN : \_\_\_\_\_ RACE : \_\_\_\_\_ BUILD : \_\_\_\_\_

HAIR COLOR : \_\_\_\_\_ OTHER PHYSICAL FEATURES : \_\_\_\_\_

MARITAL STATUS : \_\_\_\_\_ SPOUSE'S NAME : \_\_\_\_\_ # DEPENDENTS : \_\_\_\_\_

DRIVER'S LIC. # : \_\_\_\_\_ ST : \_\_\_\_\_ VEHICLES : \_\_\_\_\_

## ACCIDENT/INJURY INFORMATION

DATE OF INJURY/ACCIDENT : \_\_\_\_\_ TYPE OF INJURY(IES) : \_\_\_\_\_

JOB DESCRIPTION : \_\_\_\_\_

ACCIDENT DESCRIPTION : \_\_\_\_\_

IS SUBJECT IN PHYSICAL THERAPY? : \_\_\_\_\_ RECEIVING BENEFITS? : \_\_\_\_\_ AMT : \_\_\_\_\_

## INSURED INFORMATION

INSURER COMPANY : \_\_\_\_\_ CONTACT : \_\_\_\_\_ PHONE : \_\_\_\_\_

ADDRESS : \_\_\_\_\_

## ATTORNEY INFORMATION

IS SUBJECT REPRESENTED : \_\_\_\_\_ ATTORNEY : \_\_\_\_\_ PHONE : \_\_\_\_\_

FIRM : \_\_\_\_\_ DEFENSE FIRM : \_\_\_\_\_

DEFENSE ATTORNEY : \_\_\_\_\_ PHONE : \_\_\_\_\_

## WORK TO BE COMPLETED

SERVICE(S) DESIRED : \_\_\_\_\_ DATE DUE : \_\_\_\_\_

BUDGET : \$ \_\_\_\_\_ OR # DAYS : \_\_\_\_\_

DOES SUBJECT HAVE AN APPOINTMENT? : \_\_\_\_\_ DATE : \_\_\_\_\_ TIME : \_\_\_\_\_

LOCATION : \_\_\_\_\_ PHYSICIAN : \_\_\_\_\_

SPECIAL INSTRUCTIONS : \_\_\_\_\_

## PACKAGING - choose all that apply-

EMAIL WITH VIDEO LINK

MAIL HARD COPY WITH :  CD  VHS OR  DVD -please choose one-