

Treating Physician Copy Service Order Form

Treating Physicians and the Agreed Medical Examiner's (AME's) have the right to obtain Medical Records for an applicant to ensure that a comprehensive and complete Medical Report is generated. Under treatment or med-legal expenses the Insurance Carrier is required to pay for the costs associated with the records retrieval process. Please fill out this form so that Matrix Document Imaging, Inc., may file a lien for services rendered. Filling out this form will ensure that you will not be charged for this service. Should you have any questions please feel free to contact 626-966-9959.

- Medical History form attached for record locations.
- Signed Authorization form attached to get records.
- Intake sheet attached in lieu of case information above.

Date Ordered: _____ Date Needed: _____

INJURED WORKER INFORMATION

CASE INFORMATION

Name: _____ Injury Date(s): _____
AKA: _____

Birth Date: _____ Social: _____ Case #'s: _____

APPLICANT'S HOME ADDRESS REQUESTING DOCTOR (PTP)

APPLICANT ATTORNEY

SELECT ONE BELOW

AME TREATING PHYSICIAN

EMPLOYER'S NAME AND ADDRESS SECOND EMPLOYER'S NAME AND ADDRESS

INSURANCE CARRIER INFORMATION SECOND INSURANCE CARRIER INFORMATION

Claim #: _____ Claim #: _____
Adjuster: _____ Adjuster: _____

DEFENSE ATTORNEY

SECOND DEFENSE ATTORNEY

REQUIRED ATTACHMENTS

**FAX, Mail, or email this form with all ATTACHMENTS to Matrix using info below
Expect records in 14-21 days**

Matrix Document Imaging
www.Legal-Records.com

Medical Treatment History Form

Patient Name: _____ Case Number: _____

Date of Birth: _____ Date of Injury: _____

List the last known name and address for all medical facilities you have been treated or examined at for the last 5-10 years. Be as accurate and complete as you can.

Name:	Name:
Address:	Address:
City/ST/Zip:	City/ST/Zip:
Phone:	Phone:
Last Date:	Last Date:
File #	File #

Name:	Name:
Address:	Address:
City/ST/Zip:	City/ST/Zip:
Phone:	Phone:
Last Date:	Last Date:
File #	File #

Name:	Name:
Address:	Address:
City/ST/Zip:	City/ST/Zip:
Phone:	Phone:
Last Date:	Last Date:
File #	File #

Name:	Name:
Address:	Address:
City/ST/Zip:	City/ST/Zip:
Phone:	Phone:
Last Date:	Last Date:
File #	File #

Attach additional forms as necessary

Matrix Document Imaging

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