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 ADDRESSREQUESTING DOCTOR (PTP)
____ ____
____ ____
____

APPLICANT ATTORNEY
____
____
____
____

SELECT ONE BELOW

☐ AME ☐ TREATING PHYSICIAN

EMPLOYER'S NAME AND ADDRESSSECOND 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

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800) 737-8840 527 Rowland Street, Covina, CA 91723 (626) 966-9975 Fax

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

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