HEALTH CARE PROVIDERS

Client: _____ File#: _____ Case Type: _____

Address: _____ City: _____, State: _____, Zip: _____

Soc. Sec.#: _____ D.O.B. _____ Tel: ( ) _____

Treating Dr./Hosp. Name: _____

Address: _____

City: _____, State: _____, Zip _____

Tel: ( ) _____

Records Sent For By: _____

Date Records Sent For: _____

Date Records Recv'd: _____

Treating Dr./Hosp. Name: _____

Address: _____

City: _____, State: _____, Zip _____

Tel: ( ) _____

Records Sent For By: _____

Date Records Sent For: _____

Date Records Recv'd: _____

Treating Dr./Hosp Name: _____

Address: _____

City: _____, State: _____, Zip _____

Tel: ( ) _____

Records Sent For By: _____

Date Records Sent For: _____

Date Records Recv'd: _____

reating Dr./Hosp Name: _____

ddress: _____

ty: _____, State: _____, Zip _____

l: ( ) _____

Records Sent For By: _____

Date Records Sent For: _____

Date Records Recv'd: _____