CLAIM BACKGROUND FORM

Insurance Carrier:

Claimant Name:

Claim Number:

Date of Loss:

Loss Location State:

Coverage Type: Auto ☐ Liability ☐ WC ☐ Other ☐

Liability Policy Limits: <50k ☐ 50-100k ☐ >100k ☐

Claim Information (complete known information)

Alleged Injuries of Interest: NEURO: Cervical ☐ Lumbar ☐ Thoracic ☐ Head ☐

JOINT: Knee Left ☐ Right ☐ Shoulder Left ☐ Right ☐

OTHER:

Specific levels or areas of interest:
(C2-C3, L5-S1, ACL Tear, etc.)

Surgeries claimed from loss:

Surgeries planned from loss:

Pre-Date of loss imaging available for comparison? Yes ☐ No ☐

In Suit: Yes ☐ No ☐

No Additional Relevant Information:

Plaintiff Attorney Name/Firm:

Your Contact Info: Adjuster ☐ Staff Counsel ☐ Panel Counsel ☐

Name:

Email:

Phone:

City, State, Zip:

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