Evaluation ONLY  Evaluation &Treatment IME SCSC

Disability Fit for Duty Pre-Surgery Psych Evaluation Psychotherapy Services

**Out of State Claim? YES, What State? NO**

**Responsible Party Issuing the Check: Ins Carrier |Third-Party Claim Entity, |  Attorney’s office or|  Other**

**Clients Name**:

**DOB:**

**DOI:**

**Claim#:**

**Occupation:**

**In one sentence explain the reason why the client needs to see a psychiatrist:**

Address **(NO PO BOX ACCEPTED):**

Phone#:

Gender: Male Female

Name of Adjuster and or Person with the Authority to Approve Payments

Phone#:

**Email:**

**Supervisors Name:**

**Email:**

**Case Manager:**

**Email:**

**Phone:**

**Name of Insurance Carrier:**

**Is the Ins Carrier also the Payor who will be issuing the check? YES NO**

Billing Address:

Phone Number:

**Is the Third-Party Claim Handling Entity the Payor issuing the check  Yes, please provide (Payor) info below  No**

**Third-Party Claim Entity Name:**

Billing Address:

Phone Number:

Case Manager:

Phone#

Email:

**Claimants Attorneys name** **(write N/A if no Attorney):**

***(Please do not use the attorneys email it has to be the Paralegal email)***

Address:

Phone Number

**Paralegal Name:**

**Email**

**Employer Carrier Attorneys name (write N/A if no Attorney):**

***(Please, do not use the attorneys email it has to be the Paralegal email)***

Address:

Phone Number

**Paralegal Name:**

**Email**

**Name of Person completing this form:**