[ ] 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:**