

File No: _____
 Consultant: _____
 Date Assigned: _____
 Business Code: _____
 Client Code: _____

Office Use Only

WOIDA, LORENTZEN & ASSOCIATES, INC.

P.O. Box 5308 Phone: 989-799-5316
 Saginaw, MI 48603-0308 Fax: 989-799-5769
 www.wla-inc.com

REQUEST FOR SERVICE

Date: _____

<input type="checkbox"/> Auto No-Fault	<input type="checkbox"/> Auto Liability	<input type="checkbox"/> IME Coordination
<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> General Liability	<input type="checkbox"/> Other

REFERRAL SOURCE

Name	Claim No.	
Company	Policy No.	
Address	Telephone	
City/State/Zip	Fax	

CLAIMANT INFORMATION

Name	Social Security No.	
Address	Date of Birth	
City/State/Zip	Occupation	
Telephone	AWW/Benefit Rate	
Injury/Disability	Date of Injury	

EMPLOYER

Name	Contact Name	
Address	Title	
City/State/Zip	Telephone	

PHYSICIAN	ATTORNEY
	<input type="checkbox"/> Defense <input type="checkbox"/> Plaintiff
	Notified of our involvement? <input type="checkbox"/> yes <input type="checkbox"/> no

Name	Name	
Address	Address	
City/State/Zip	City/State/Zip	
Telephone	Telephone	

SPECIFIC SERVICES REQUESTED