



PREMIER MEDICAL GROUP, INC.

Telephone: (800) 998-9777 • Fax: (800) 265-2544 Diagnostic Coordinator _____

❖ INSURANCE FORM (PLEASE COMPLETE THIS FORM AND FAX TO THE NUMBER ABOVE)

Commercial Health Insurance Personal Injury Worker's Comp Lien

X REFERRING DOCTOR: _____

> TYPE OF TEST REQUESTED

X DEP/NCV: Upper Series Lower Series Full Series

 * EMG: Upper Series Lower Series Full Series

 Spinal Ultrasound: Upper Series Lower Series Full Series

 Extremity Ultrasound: Foot/Ankle - R or L

**Only available in select states*

^Personal Services Program Only

> PATIENT INFORMATION

X Name (Last, First): _____ X SSN: _____

X Address: _____ X City/State/Zip: _____

X Home Phone: _____ X Work Phone: _____

X Employer: _____ X Birth Date: _____ Sex: M F

> INSURED INFORMATION (IF NOT SAME AS ABOVE)

Name (Last, First): _____

Birth Date: _____ SSN: _____

Address: _____ City/State/Zip: _____

> ATTORNEY (IF APPLICABLE)

Firm Name: _____

Address: _____ City/State/Zip: _____

Telephone: _____ Date of Loss: _____

> PRIMARY

X Insurance Company: _____

X Address: _____ X City/State/Zip: _____

X Contact: _____ X Telephone: _____

X Claim/File No.: _____ X Policy No.: _____

X Date of Onset: _____

> SECONDARY

Insurance Company: _____

Address: _____ City/State/Zip: _____

Contact: _____ Telephone: _____

Claim/File No.: _____ Policy No.: _____