Tel # 201-933-2388
Fax # 201-933-6970

CONFIDENTIAL

P.A.S., Inc.

Professional Appointment Services, Inc.

Medical Examination Request

P.A.S., Inc.
P.O. BOX 371
RUTHERFORD, N.J. 07070-0371

DATE ______________

ACCT # ______________

REQUESTOR ______________

PHONE # ______________ Ext. ______

FAX # ______________

(Please print or type)

1. Please arrange an appointment for:

   Policy # ______________ Claim # ______________ SS # ______________

   Claimant (M or F) ______________ Date of Birth ______________
   Circle One

   Street ______________

   City ______________ State ______ Zip ______

   Phone # ______________

   Occupation ______________

   Employer ______________ Length of Service ______

   Type of Policy ______________ Date of Disability ______

   Nature of Disability ______________

   ____

2. Physicians not to be used for this examination such as attending physician or previous medical examiners.

   ____

3. Type of Specialist required ______________

4. If you wish to set a maximum fee, state physician's fee ______________ Testing Fee ______________

5. Do you wish P.A.S. to write the letters to the physician and the claimant? Yes ☐ No ☐

6. Do you wish P.A.S. to PHONE you with the appointment information prior to the mailng of your written confirmation? Yes ☐ No ☐

7. Do you want the claimant's letter sent by certified mail (Return-Receipt)? Yes ☐ No ☐

8. If possible do you want this examination scheduled for earlier than 2 weeks and physician/claimant correspondence sent by express mail? Yes ☐ No ☐

9. Instructions or policy definitions to be given special attention by the examining physician. **(PLEASE ATTACH)**

   ____

10. Will you be forwarding claimant's medical records? Yes ☐ No ☐

Original to P.A.S.

Copy for your file