Paradigm Medical Services

REQUEST FOR MEDICAL
COST MANAGEMENT SERVICES

Requesting Party Information

Contact ______________________________

Address ______________________________

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Email ______________________________

Phone ______________ Fax ______________

Submission Date ______________ Date of Accident ______________

Claimant Information

Claimant/Patient Name ______________________________

Social Security # ______________________________

Insured/Employer ______________________________

Your File Number ______________________________

Insurance Company ______________________________

Can payment of agreed audit be paid within 10 days? ☐ Yes ☐ No

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