AUTHENTIC4D

MAKE BETTER DECISIONS CONFIDENTLY

CLAIM BACKGROUND FORM

Insurance Carrier:

Claimant Name:

Claim Number:

Date of Loss:

Loss Location State:

Line of Business: Auto ○ General Liability ○ WC ○ Other ○

Insured/Employer (required):

Coverage Type: BI ○ PIP ○ UM ○ UIM ○

Liability Policy Limits: <50k ○ 50-100k ○ >100k ○
(For client reporting only)

Claim Information (complete known information)

Alleged Injuries of Interest: NEURO: Cervical: ☐ Lumbar: ☐ Thoracic: ☐ Head: ☐

JOINT: Knee: Left: ☐ Right: ☐ Shoulder: Left: ☐ Right: ☐

OTHER:

Specific levels or areas of interest:
(C2-C3, L5-S1, ACL, Tear, etc.)

Surgeries claimed / planned:

Pre-Date of loss imaging available for comparison? No ○ Yes ○

In Suit? No ○ Yes ○

EMG report available for review? No ○ Yes ○

Additional Relevant Information:

Primary Contact Information		Secondary Contact Information (optional)	
Name:		Name:	
Email:		Email:	
Phone:		Phone:	
City, State:		City, State:	

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