AUTHENTIC4D

MAKE BETTER DECISIONS CONFIDENTLY

SECONDARY 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 ☐

Product Selection(s)

Imaging Review No ☐ Yes ☐ If Yes, check all that apply MRI: ☐ CT: ☐ X-Ray: ☐

EMG Review No ☐ Yes ☐

Claim Information (complete known information)

Body part(s) for review: 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 ☐

Additional Relevant Information:

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

(844) 334-6243 orders@authentic4d.com
30800 TELEGRAPH RD., SUITE 4775
BINGHAM FARMS, MI 48025