THE CENTERS

Medical Report Intake Form
Medical Malpractice

Law Firm: Contact Person/Number:		Client/Case Name: Age: DOB:
Date of Injury:	Date Sent to CLS:	Deadline:
Brief Description of Incident and Injury:		
Date of Death (if applicable):		Family/Client Diary: ☐ YES ☐ NO
Currently Treating: ☐ YES ☐ NO		Permanent Injury: ☐ YES ☐ NO
Medical and Billing Records: ☐ HAVE ☐ NEED TO OBTAIN		

Healthcare Provider Information:

Medicare:	☐ YES	☐ NO	
Medicaid:	☐ YES	☐ NO	
Private Insurance:	☐ YES	☐ NO	If Yes, Provider Name: _____
Tri-Care/VA Coverage:	☐ YES	☐ NO	If Yes, Provider Name: _____
Other Coverage:	☐ YES	☐ NO	If Yes, Provider Name: _____

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Document Checklist

- ☐ Complaint
- ☐ Interrogatories
- ☐ HIPAA Form, signed and up to date

  (only applicable for Medical Record Retrieval services)
- ☐ Hospital records
- ☐ Primary Care Physician records
- ☐ Additional treating physician records
- ☐ Medical bills from all treating facilities
- ☐ Therapy records
- ☐ Employment records for wage loss verification
- ☐ Documentations of out-of-pocket expenses
- ☐ Medical examiner evaluation report (if applicable)

Optional Records (may be beneficial depending on case)

- ☐ Policies and procedures manual for facility in question
- ☐ Family or client diary/summary of events and discussions with healthcare providers
- ☐ Photographs of injuries (if applicable)

Medical Records Analysis Disclosure: After review of medical records received to date, further medical record retrieval may be necessary in order to complete full medical case analysis. A summary of the records required will be forwarded for your review and retrieval will begin upon your authorization. Additional record retrieval fees will apply to amended retrieval efforts.

Completed By: _____ **Date:** _____