Date: _____ **Medical Evaluations of Alaska, Inc.**

Customer Information

Name: _____

Company: _____

Phone: _____

E-Mail: _____

☐ Cover Letter

Others Involved in Claim Management

☐ Attorney ☐ Nurse Case Manager ☐ Rehab ☐ Other

Name: _____

Company: _____

Phone: _____

E-Mail: _____

☐ Trial Date

Examinee Information

Previous MEA Evaluation? Date: _____ ☐ Chart in Stand

(Mr.) or (Ms.) Last Name: _____ First: _____ MI: _____

(C/O) (CC) Attorney Address: _____

Examinee Address: _____

City: ☐ Anchorage ☐ E. River ☐ Wasilla ☐ Palmer ☐ Fairbanks ☐ Other _____ Zip: _____

Phone Number (s): _____ _____ _____

Date of Birth: _____ Claim No: _____ Date of Injury: _____

Treating Doctor(s): _____

Purpose of Evaluation: _____

To Be Examined: ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Shoulder ☐ Elbow ☐ Wrist / Hand ☐ Hip

☐ Knee ☐ Ankle / Foot ☐ Headache ☐ Psych ☐ Other Inches of Med Records _____

☐ Interpreter: _____ Language: _____

☐ Video: _____ Confirmed: _____

Evaluation Information

Doctors & Specialties: _____

Evaluation Date: _____ Time: _____

RS1: _____ New Date: _____ Time: _____

RS1: _____ New Date: _____ Time: _____

Office Use Only

☐ Called in ☐ Staff Called ☐ Date Confirmed: _____ By: _____

Invoice #: _____ Date: _____ Initials: _____ ☐ cc Report to: _____

Invoice #: _____ Date: _____ Initials: _____ ☐ cc Report to: _____

Invoice #: _____ Date: _____ Initials: _____ ☐ cc Report to: _____