

Doctor's Application Form

Date: _____

**ARROW
CLAIMS
SERVICES, Inc.**

Tel. # (718) 460-6900

Fax # (718) 460-6924

www.arrowclaims.com

Doctor's Name: _____

Title: _____ Specialty: _____

Phone #: _____ Fax #: _____

LIC#: _____

Tax ID#: _____

SS#: _____

WCB Authorization #: _____

Fee: _____ No Show : _____ Rev: _____

Primary Address: _____

Office Name: _____

City, State, Zip: _____

Please note that the **Primary Address** will receive all correspondence and medical documents with concern to claimant.

Dear Sir/Madam,

Welcome to our panel of medical experts. As agreed, you will conduct Independent Medical Evaluations on behalf of our clients.

Please fill out this form, include a copy of your CV, License and fax back to us. Please include any other office locations you may have.

Since our clients need to process their files quickly, we request that you submit your report to us within 5 business days from the date of the examination.

Thank you for your prompt attention.