Express DME

3000 Gulf to Bay Boulevard, Suite 213
Clearwater, FL 33759

DETAILED WRITTEN ORDER FAX TO: 727.203.5386

PATIENT NAME: _____ D.O.B. _____/_____/_____

ADDRESS _____

SSN: _____ MRI Facility _____

PATIENT EMAIL: _____ PHONE #: (_____)_____

DATE OF LOSS: _____/_____/_____TYPE OF INJURY (MVA/WC/SLIP & FALL) _____

REFERRING PHYSICIAN: _____ PHONE #: (_____) _____

PRIMARY HEALTH INSURANCE NAME: _____

ADDRESS: _____ POLICY # _____

INSURANCE PROVIDER PH# ON BACK OF CARD _____

SECONDARY HEALTH INSURANCE NAME: _____

ADDRESS: _____ POLICY # _____

INSURANCE PROVIDER PH# ON BACK OF CARD _____

AUTO INSURANCE NAME _____

CLAIM NUMBER _____ ADJUSTER NAME AT INSURANCE CO: _____

ADJ. OR INS. CO. PHONE #: (_____) _____ FAX AT INS CO: (_____) _____

INSURANCE PROVIDER PH# ON BACK OF CARD _____

LAW FIRM: _____ CASE MANAGER AT LAW FIRM _____

PHONE #: (_____) _____ FAX #: (_____)_____

EMAIL ADDRESS LAW FIRM WANTS RECORDS SENT TO: _____

- ❑ **Lumbar**
- ❑ **Knee**
- ❑ **Foot (Tall / Short)**
- ❑ **Wrist**
- ❑ **Tens Units**
- ❑ **Cervical**
- ❑ **Elbow**
- ❑ **Other**_____