**Medical Management Group of New York, Inc.**

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Suite 104
Bohemia, NY 11716
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NY 631.467.7766
NJ 732.885.5850
FAX 631.589.2331

# APPOINTMENT REQUEST

DATE: _____

CLIENT: _____

Address: _____

_____

ADJUSTER: _____

CLAIMANT: _____

Address: _____

_____

Phone: _____

S.S. #: _____ Birth Date: _____

CLAIMANT'S ATTORNEY: _____

Address: _____

_____

Phone: _____

INSURED/EMPLOYER: _____

DATE OF ACCIDENT: _____

CLAIM #: _____

WCB #: _____ WCB OFFICE: _____

TREATING PHYSICIAN: _____

_____

DEFENSE FIRM: _____

Handling Attorney: _____

Address: _____

_____

File #:_____

Are medical records attached? Yes ◯ No ◉

Has MMG previously scheduled and IME? Yes ◯ No ◉

==========**SPECIALTIES AND COVERGES**==========

☐ Internal Medicine ☐ Neurology ☐ Radiology ☐ Psychology ☐ Physiatry (P.M.&R) Other:_____

☐ Orthopedics ☐ Chiropractic ☐ Plastic Surgery ☐ Psychiatry ☐ Acupuncture _____

☐ **WORKERS' COMP**
☐ Degree of Disability
☐ Causal Relationship
☐ Need For Treatment
☐ Return to Work (Full/Light)
☐ Schedule Loss Evaluation
☐ Appointment
☐ M&S Issues

☐ **NO-FAULT**
☐ Need For Treatment
☐ Casual Relationship
☐ Return to usual Occupation?

☐ **LIABILITY**
☐ Venu_____
☐ Permanency

☐ **SHORT TERM DISABILITY**
☐ Return to usual occupation?

**ANCR**_____

**Is this claim bound by the New York State Workers' Compensation Board? Yes ◯ No ◉**

**SPECIAL INSTRUCTIONS:** _____

_____

_____

*OFFICE USE ONLY BELOW THIS LINE*

Date: _____ MMG File #: _____

Time:_____

Doctor: _____

*Quality Service Integrity Since 1989*

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