Professional Medical Copies, Inc.

D.I.M.E. RECORDS PREPARATION SERVICE REQUEST

Injured party: W.C. Number:

Date of Injury: (MM/DD/YYYY)

Ins. Co: Claim Number:

Claim Representative: Phone:

Email: Fax:

Defense Counsel: Phone:

Email: Fax:

Mailing Address:

City/State: Zip:

Claimant or Attorney: Phone:

Email: Fax:

Mailing Address:

City/State: Zip:

Selected Physician: Phone:

Date of Physician Selection confirmation: (MM/DD/YYYY)

Email: Fax:

Mailing Address:

City/State: Zip:

Appointment Address:

City/State: Zip:

If scheduled, Appointment Date (MM/DD/YYYY): Appointment Time (HH:MM am/pm):

Preferred Records format:	hard copy	disk	encrypted email
Doctor:	☐	☐	☐
Claimant or Attorney:	☐	☐	☐
Carrier Attorney:	☐	☐	☐
Claim Representative (Optional):	☐	☐	☐

Special Instructions or concerns:

***If you would like to transmit your records to us electronically, please send them via encrypted email to mary@promedcopies.com, or via secure upload link.

PMC Signature:_____Date:_____PageCount:_____

Mailing Address: P.O. Box 4518, Parker, CO 80134♦Shipping: 8108 Oak Briar Way, Castle Pines, CO 80108
Phone (303) 850-9594 ♦ Fax (303) 850-9598

https://promedcopies.com