

---APPS FAX---

(614)-839-2784 or (877)-APPS FAX toll free

Paramedical Request Form:

(Please print or type all information)

Client: _____ Male Female
First Name M.I. Last Name

Social Security Number: _____ - _____ - _____ Date of Birth: _____ - _____ - _____

Home Address: _____
City Zip

Business Address: _____
City Zip

Home Phone: () _____ Work: () _____ Cell: () _____

Best time to Contact: _____ Preferred Exam Location: _____

Insurance Company: _____ Home Office: _____

Agent: _____ Agency: _____ Phone: _____

Agent Email Address: _____

Type (please circle): Life Disability Health Long Term Care Reconsideration

Amount of Insurance: \$ _____ Preferred _____ Standard _____ Other _____

Requirements: Please check

- | | | |
|---|---|---|
| <input type="checkbox"/> Paramedical Exam | <input type="checkbox"/> Blood (full blood profile) | <input type="checkbox"/> EKG |
| <input type="checkbox"/> Urine Only | <input type="checkbox"/> Finger stick Blood | <input type="checkbox"/> TVC |
| <input type="checkbox"/> Physician Exam | <input type="checkbox"/> X-Ray | <input type="checkbox"/> Treadmill EKG |
| <input type="checkbox"/> HIV Consent Form | <input type="checkbox"/> Saliva | <input type="checkbox"/> Urine HIV test |
| <input type="checkbox"/> Other/Non Standard Requirements: _____ | | |

Special Instructions: _____

Prepared By: _____ Date: _____

Requestor Email Address: _____

Send exam to: _____



APPS Paramedical
5050 B Pine Creek Dr. Westerville, OH 43081
Phone: 614-839-APPS (2777) Toll Free: 800-852-4469
Order On Line at: www.appspamedical.com