Paramed Express INC Fax Order Form

(708)-485-7407

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

_____ Paramedical Exam _____ Blood (full blood profile) _____ EKG

_____ Urine Only _____ Finger stick Blood _____ Saliva

_____ Other/Non Standard Requirements: _____

Special Instructions: _____

_____

Prepared By: _____ Date: _____

Requestor Email Address: _____

Send exam to: _____

Paramed Express INC
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Fax/Phone: 708-485-7407
Order Online at: www.paramedexpressinc.com