

[Date]

[Medical Provider Name]

[Facility Name]

[Address]

[City, State, Zip Code]

RE: REQUEST FOR MEDICAL RECORDS

Patient Name: [Claimant Name]

Date of Birth: [DOB]

Date of Injury: [DOI]

Claim Number: [Claim Number]

To Whom It May Concern,

This office represents [Employer/Insurance Carrier Name] regarding the workers' compensation claim filed by the above-referenced individual.

In order to evaluate this claim, please provide copies of all medical records in your possession regarding the treatment of this patient from [Start Date] to present. This request includes, but is not limited to:

- Initial evaluation and progress reports
- Diagnostic test results (X-rays, MRI, CT scans)
- Physical therapy or rehabilitation notes
- Itemized billing statements
- Work status slips and functional capacity evaluations

Attached is a signed medical authorization form executed by the claimant. Please send the requested documents to my attention via [Email/Fax/Mail Address].

If there is a fee for this service, please provide an invoice and we will issue payment promptly.

Thank you for your cooperation.

Sincerely,

[Adjuster Name]

[Title]

[Insurance Company Name]

[Phone Number]