AMBR, INC
PO Box 492710
Redding, CA 96049-2710
530/221-4759 TEL
530/224-3390 FAX

MedWatch Referral Form

Company Name: _____ Date: _____

Address: _____ No. of Pages: _____

City: _____ State: _____ Zip Code: _____

Tele: _____ Fax: _____

Adjuster Name: _____ Phone Ext: _____

Adjuster Email: _____

Insured/Claim Name: _____

Claim Number: _____ Date of Injury: _____

Diagnosis: _____

First Date of Treatment: _____ Number of Visits to Date: _____

Number Work Days Missed: _____

Attorney Representation: Yes _____ No _____ Telephone: _____

Facts of Accident / Concerns / Present Situation

Provider Information

Name:	Telephone:	Address:

PLEASE FAX or EMAIL THIS FORM WITH MEDICAL AUTHORIZATION TO:
FAX: 530-224-3390 Email: claims@ambr.com