



REQUEST FOR BIO-MECHANICAL ANALYSIS

Your Company Name _____

Address _____

City, State, Zip _____

Phone Number _____

Date: _____ **Number of Pages** Including Cover Sheet: _____

How do you want the review returned? Mail: Email: Secure website

Original Bills Mailed Back? Yes: No:

1. Insured: _____ 2. Claimant: _____

3. Date of Injury: _____ 4. File/Claim Number: _____

5. Claims Representative: _____ Extension: _____

6. E-mail: _____

Description of How Accident Occurred: _____

Vehicle Descriptions:

Insured Vehicle: Driver: _____ Age: _____

Injured: Yes No Airbag Deploy: Yes No

Vehicle Year: _____ Make: _____ Model: _____

VIN number: _____ (Required)

If the vehicle is a truck or van, was it loaded or empty? _____

Passengers in Vehicle (please list ALL passengers):

#1: _____ Age: _____ Location in Vehicle: _____ Injured: _____

#2: _____ Age: _____ Location in Vehicle: _____ Injured: _____

#3: _____ Age: _____ Location in Vehicle: _____ Injured: _____

#4: _____ Age: _____ Location in Vehicle: _____ Injured: _____

Anyone **not** using a seatbelt: No: Yes: Whom: _____

Claimant Vehicle: Driver: _____ Age: _____
Injured: Yes No Airbag Deploy: Yes No

Vehicle Year: _____ Make: _____ Model: _____

VIN number: _____ (Required)
If the vehicle is a truck or van, was it loaded or empty? _____

Passengers in Vehicle (please list ALL passengers):

#1: _____ Age: _____ Location in Vehicle: _____ Injured: _____
#2: _____ Age: _____ Location in Vehicle: _____ Injured: _____
#3: _____ Age: _____ Location in Vehicle: _____ Injured: _____
#4: _____ Age: _____ Location in Vehicle: _____ Injured: _____

Anyone **not** using a seatbelt: No: Yes: Whom: _____

Road Conditions (dry, wet, icy, etc.): _____

Final Resting positions of vehicles (relative to point of impact)

Vehicle 1: _____

Vehicle 2: _____

Distance Vehicles Traveled after impact (in feet):

Vehicle 1: _____

Vehicle 2: _____

What were the vehicles doing prior to impact?

Insured Vehicle: Moving forward: Stopped: Turning: Braking:
Claimant Vehicle: Moving forward: Stopped: Turning: Braking:

Additional Information: _____

Please attach the following, if available. Please check if submitted:

Medical Records: (Enough info to document the type of injuries claimed)
Police Report:
Written Statements: Insured: Claimant: Witness:
Repair Estimate: Insured Vehicle: Claimant Vehicle:
Vehicle Photos: Insured Vehicle: Claimant Vehicle:
Scene Photos:
Other (describe): _____

Specific questions you need answered to evaluate/negotiate this claim:

**Send all file materials to the address listed below or email them to claims@ambr.com
Please contact us with any questions regarding this assignment. Most reports are
completed in approximately 5 business days. Thank you for using AMBR.**

American *Medical* Bill Review
P.O. Box 492710
Redding, CA 96049-2710

Or our physical address:

1160 Industrial St
Redding, CA 96002

530-221-4759 Phone
530-224-3390 FAX