LSI

Litigation Solutions Incorporated

Canvass Request Form

Today's Date:

Requestor's Information

Name:	
Company:	
Address:	
Telephone:	**Fax:**
Email Address:	
File or Claim#:	**Type of Claim:**

Bill To Information

(Please complete, if different from above Requestor Information.)

Name:	
Company:	
Address:	
Telephone:	**Fax:**
Email Address:	
File or Claim#:	**Type of Claim:**

Claimant's Information

Name:		**Male or Female?**	
Date of Birth:		**SSN:**	
Address:			
Date of Loss:		**Injury:**	

Search Areas (If different than claimant's address):

Please Check the Appropriate Search Request:
(Limit of 10 Separate Canvass Locations Per Canvass)

☐ **Hospital Canvass** **How Many Hospitals:**

☐ **Pharmacy Canvass** **How Many Pharmacies:**

☐ **Clinic Canvass** **How Many Clinics:**

Specify the type of clinic:

☐ **MRI Canvass** **How Many Facilities:**

☐ **Chiropractor Canvass** **How Many Chiropractors:**

☐ **Doctor Canvass** **How Many Doctors:**

Would you like to extend beyond 10 canvasses? If so, how many?

If you are searching for any specific dates or types of treatment, please list below.

Locations of Previous Treatment

Name of Provider	Address	Telephone	Dates of Service	Please check if you wish to include this provider in your canvass.
				☐
				☐
				☐
				☐
				☐

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