Document and Imaging Services
4510-D Pennsylvania Avenue
Charleston, WV 25302
Phone: 304-558-1966 ext. 3500
Fax: 304-558-1021

REQUEST for Original X-Rays

Requester Information:

Name:	
Address:	
City/State/Zip:	
Phone:	

Requested Claimant Information:

Claimant Name:	
Claim #:	
Date of Injury:	
Date of Birth:	
SSN #:	

A signed release form (e.g. attorney contract, subpoena, etc.) must be attached if the requester is someone other than the claimant or the employer.

PLEASE NOTE:

A separate "Request for Original X-Rays" form must be completed for each file requested. Requests containing multiple claims will be returned.

A Protective Order must be attached with the Request for Original X-Rays form and the Protective order must include the date the X-Rays will be returned to the Offices of the Insurance Commissioner.

Please allow at least 10 business days from the date of receipt for completion of the request.

Please provide a brief description for this request below:

Requester's Signature: _____ Date: _____

Relationship to the Claimant or Employer: _____