west virginia
OFFICES OF THE
INSURANCE
COMMISSIONER

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

REQUEST for X-Rays

Requester Information:		**Requested Claimant Information**:	
Name:		Claimant Name:	
Address:		Claim #:	
City/State/Zip:		Date of Injury:	
Phone:		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 X-Rays" form must be completed for each file requested. Requests containing multiple claims will be returned.

The information in response to the request will be provided on a CD.

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: _____