



**APPLICATION FOR INSURANCE CLAIM
TO BE FILED BY DEFINED FITNESS**

***** THE FOLLOWING MUST BE FILLED OUT COMPLETELY, AND COPY OF ORIGINAL DOCTORS PRESCRIPTION ATTACHED IN ORDER FOR CLAIM TO BE FILED. *****

DATE: _____

LOCATION PAPER WORK SUBMITTED: RS _____ RR _____ SM _____ JT _____ FN _____

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP _____

PHONE: (HOME) _____ **(WORK/CELL)** _____

SOCIAL SECURITY NUMBER: _____

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

ADJUSTER OR CONTACT PERSON: _____

PHONE: _____

DOCTORS NAME: _____ **PHONE:** _____

LENGTH OF TIME OF MEMBERSHIP: _____

TYPE OF INJURY: _____

DATE OF INJURY: _____

CLAIM NUMBER: _____

***** PLEASE FILL OUT BACK OF PAGE *****