



**Roxanne M. Massey  
Rating Services**

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**RATING REQUEST SHEET**

**INSTRUCTIONS:** Please complete this form and E-Mail to [IratePD@aol.com](mailto:IratePD@aol.com) along with a copy of the physician's report.

**Type of Service:**

**1997 Schedule Rating**

**AMA Rating**

**Normal (5-7 Business Days)**

**Rush (1-2 business days)**

**SAME DAY**

**How do you want your rating returned**

**Fax**

**E-Mail**

**REQUEST MADE BY:** \_\_\_\_\_

Company name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Rating will be e-mailed in PDF format.

**PHYSICIAN'S NAME:** \_\_\_\_\_

**DATE OF REPORT:** \_\_\_\_\_

**EMPLOYEE**

Name: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Date of injury: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_

JOB TITLE: \_\_\_\_\_

JOB Description: