Type of Claim:

- ☐ Workers' Comp
- ☐ Auto Liability
- ☐ General Liability
- ☐ Ocean Marine
- ☐ STD
- ☐ LTD
- ☐ Medical Management
- ☐ Jones Act
- ☐ Longshore
- ☐ F.E.L.A.
- ☐ F.E.C.A.
- ☐ Railroad
- ☐ Other

REQUESTED BY

NAME____________________

COMPANY NAME____________________

ADDRESS____________________

CITY__________ STATE______ ZIP______

TELEPHONE____________________

TITLE____________________

____

YOUR FILE NO.____________________

DATE OF INJURY (DISABILITY)____________________

CLAIMANT

NAME____________________

COMPANY NAME____________________

ADDRESS____________________

CITY__________ STATE______ ZIP______

TELEPHONE____________________

S.S.#__________ BIRTHDATE__________

OCCUPATION____________________

AVERAGE HOURLY WAGE/BENEFIT RATE____________________

HAS CLAIMANT BEEN ADVISED OF OUR INVOLVEMENT? ☐ YES ☐ NO

EMPLOYER

NAME____________________

COMPANY NAME____________________

ADDRESS____________________

CITY__________ STATE______ ZIP______

CONTACT NAME____________________

TITLE____________________

TELEPHONE__________ EXT.______

DATE OF HIRE____________________

ATTORNEY ☐ YES ☐ NO ☐ UNKNOWN

NAME____________________

ADDRESS____________________

CITY__________ STATE______ ZIP______

TELEPHONE (______)____________________

HAS CLAIMANT'S ATTORNEY BEEN ADVISED OF OUR INVOLVEMENT?

☐ YES ☐ NO

PHYSICIAN

NAME____________________

ADDRESS____________________

CITY__________ STATE______ ZIP______

TELEPHONE (______)____________________

INJURY OR DISABILITY____________________

____

SPECIFY SERVICES REQUESTED / HANDLING INSTRUCTIONS

____

____

____

____

____

INTEROFFICE USE ONLY

OUR FILE NO.____________________

CONSULTANT____________________

DATE OF REFERRAL____________________

COPIES OF REPORTS TO:

☐ Same as Person Referring

☐ Other ____________________

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