



LITIGATION REFERRAL

ADJUSTER

CARRIER/ADMINISTRATOR

Name: _____ Name: _____

Address: _____

City, State, Zip: _____ Insurer: _____

E-Mail: _____ (If different then carrier name)

Phone: _____

Fax: _____ Permissibly Self-Insured Certificate Name: _____

CASE INFORMATION

Applicant Information: _____ **Employer Information:** _____

Name _____ Contact Name: _____

Address: _____ Firm Name: _____

City, State, Zip: _____ Address: _____

Phone: _____ City, State, Zip: _____

SSN: _____ Phone: _____

DOI: _____ Fax: _____

DOB: _____ Date of Knowledge: _____

Occupation: _____ Date of Hire: _____

Policy Number: _____ Language: _____

Coverage dates: _____

AWW: _____ TTD Rate: _____

If Permissibly Self-Insured, Initial date of PD Rate _____ certificate: _____

Admitted, Delayed or Accepted?: _____

Parts of Body Admitted: _____

Parts of Body Denied/Disputed: _____

Claim No.: _____ WCAB No.: _____

Decision Date: _____ Hearing Date: _____



LITIGATION REFERRAL CONTINUED

Applicant Attorney Information:

Name: _____
Firm Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

Primary Treating Physician:

Name: _____
Medical Facility Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

PTP Election Valid? Yes No

MPN?

MPN info (web site)

Co-Defendant Information: _____

Contact Name: _____
Carrier Name: _____
Address: _____
City, State, Zip: _____
Fax: _____

Co-Defendant Attorney Information _____

Contact Name: _____
Firm Name: _____
Address: _____
Phone: _____
Fax: _____

LITIGATION STRATEGY/COMMENTS:

Settlement Authority?

Schedule Deposition of Applicant? Yes No