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LITIGATION REFERRAL

DATE: _____

CARRIER/TPA NAME: _____

ADMNISTRATING FOR:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

ADJUSTER NAME: _____ TEL/EXT:_____EMAIL:_____

APPLICANT: _____ EMPLOYER: _____

ADDRESS: _____ ADDRESS: _____

WCAB NO.: _____ CLAIM NO.: _____

DATE(S) OF INJURY: _____ DOB: _____ SOC SEC #: _____

APPLICANT'S ATTORNEY: _____ TEL: _____

ADDRESS: _____

COVERAGE OR PSI PERIOD: _____ TO _____

EMPLOYMENT PERIOD: _____TO _____ AVERAGE WEEKLY WAGES: $_____

PD PAID: $ _____ FROM: _____ TO _____TOTAL PD ADVANCED: $ _____

TD RATE: $ _____TD PAID: $_____ FROM: _____ TO _____

HEARING DATE/TIME: _____

AUTHORIZATION FOR CASE WORKUP: SET DEPO: _____ SET MEDICAL EVALUATION _____

SUGGESTED ISSUES: (PLEASE CHECK)

_____ **EMPLOYMENT**
_____ **OCCUPATION**
_____ **INJURY**
_____ **COVERAGE**
_____ **PERMANENT DISABILITY**
_____ **TEMPORARY DISABILITY**
_____ **FURTHER MEDICAL CARE**
_____ **SELF-PROCURED MEDICAL CARE**
_____ **EARNINGS**
_____ **DEPENDENCY**
_____ **STATUTE OF LIMITATION**
_____ **APPORTIONMENT**
_____ **JURISDICTION**
_____ **SJDB/VOCATIONAL REHABILITATION**
_____ **SUBROGATION**
_____ **LC5402 (90 DAYS)**

MEDICAL PREPARATION:

ORIGINAL MEDICAL REPORTS ARE:

_____ **ATTACHED**
_____ **FILED**

COPIES SERVED ON APPLICANT:

_____ **YES** _____ **NO**

HAS FURTHER MEDICAL EXAM BEEN SCHEDULED?

_____ **YES** _____ **NO**

IF YES, WITH WHOM: _____

WHEN: _____

APPLICANT'S MEDICAL / LEGAL LIENS PAID:

_____
_____
_____
_____
_____

BODY PARTS INJURED _____

REMARKS:

_____

_____

_____