# Referring Source Contact Information

Referral Contact Name/Title:

Phone/Fax:

Email Address:

Company Name:

Address:

Time Zone:

Services Requested (be specific):

# Injured Workers Information

Claim Type (Auto or Workers Comp):

Claim #:

Name:

Address:

Phone:

Date of Birth:

Occupation:

Date of Injury:

Last Day of Work:

Wage (AWW):

Jurisdiction (state of injury):

Type of Injury:

Employer at Injury:

Employer Contact Name:

Employer Contact Phone:

Employer Address:

## Attorney & Physician Information

Defense Attorney (if any):

Address/Phone:

Plaintiff Attorney (if any):

Address/Phone:

Treating Physician:

Address/Phone:

## Insurance Information

Insurance Company:

Address:

City/State/Zip:

Adjusters Name:

Phone/Fax:

Adjusters Email:

Type of Insurance:

Company where invoices will be submitted:

Contact person/phone for invoicing questions:

Name of person completing this form:

Title:

Date:

Injured workers name:

Injured workers claim #:

By submitting this form you/your company agree to Life Transitions Therapy billing/invoicing terms. All invoices have the following terms: Net 30.

Save this form to your computer and email as an attachment to: [lifetransitionstherapy@gmail.com](mailto:lifetransitionstherapy@gmail.com)