# REFERRAL FORM

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| **CLAIM NUMBER** | |
| **CLAIMANT INFO** | |
| **NAME** | |
| **CONTACT (IF NOT CLMT)** | |
| **ADDRESS** | |
| **PHONE/FAX** | |
| **EMAIL** | |
| **DOB** | |
| **DOL/DOI** | |
| **DATE DISABILITY BEGAN** | |
| **COMPENSABLE BODY PART** | |
| **DIAGNOSIS** | |
| **INSURANCE INFO (CARRIER)** | |
| **COMPANY** | |
| **FILE HANDLER (ADJ/TMCM)** | |
| **ADDRESS** | |
| **PHONE/FAX** | |
| **EMAIL** | |
| **EMPLOYER INFO** | |
| **COMPANY** | |
| **CONTACT** | |
| **ADDRESS** | |
| **PHONE/FAX** | |
| **EMAIL** | |
| **CONTACT W/ EMP REQUIRED?** | YES / NO |
| **ATTORNEY INFO** | |
| **FIRM** | |
| **CONTACT (ATTY/PARALEGAL)** | |
| **ADDRESS** | |
| **PHONE/FAX** | |
| **EMAIL** | |
| **CONTACT W/ CLMT PERMITTED?** | YES / NO |
| **NOTES/COMMENTS** | |
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