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REFERRAL FORM

FULL REFERRAL

LEGAL ANALYSIS ONLY

RATING REQUEST

ADJUSTER NAME:		
E-MAIL ADDRESS:		
COMPANY NAME:		
ADDRESS:		
PHONE #:	FAX #:	
APPLICANT'S NAME:		
ADDRESS:		
SOC. SEC. #	DATE OF BIRTH:	
APPLICANT'S ATTORNEY:		
FIRM NAME:		
ADDRESS		
PHONE #:	FAX #:	
EMPLOYER NAME:		
CONTACT PERSON:		
ADDRESS:		
PHONE #:	FAX #:	
POLICY #:	PERIOD:	
DATE OF INJURY:	CLAIM #:	
TTD PAID:	RATE:	PERIODS:
PPD PAID:	RATE:	PERIODS:
MEDICAL PAID:		
ADJ CASE #:	OCCUPATION:	
COMMENTS:		

ISSUES

- DWC-1
- L.C. §5402
- QME NEEDED
- AME NEEDED
- COVERAGE
- INJURY AOE-COE
- EMPLOYMENT
- OCCUPATION
- PARTS OF BODY
- MEDICAL-LEGAL
- EXPENSES
- MED-TREATMENT
- L.C. §4650(d)
- DEATH BENEFITS
- STATUTE OF LIMITATIONS
- SJD BENEFITS
- SELF-PROCURED MEDICAL
- JURISDICTION
- OTHER

FOR RATING REQUEST(S):

- OLD SCHEDULE
- NEW SCHEDULE
- ADMITTED BODY PARTS
- DENIED BODY PARTS

MEDICAL REPORT(S) TO BE RATED:

RIVERSIDE
(951) 353-8750 FAX (951) 353-1074

OAKLAND
(510) 893-6000 FAX (916) 419-6663

REDDING
(530) 246-9061 FAX (530) 246-0781

SACRAMENTO
(916) 419-6662 FAX (916) 419-6663

SANTA ANA-ORANGE
(714) 558-3751 FAX (714) 973-4736

SALINAS
(831) 444-7736 FAX (916) 419-6663

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