Date of Loss: _____

Claim Number: _____

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REFERRAL FORM

PLEASE EMAIL TO: cases@lemieuxassociates.com

Kindly include any Police Report with this form.

Referral Date:_____ Rush: ☐ Yes ☐ No Due Date:_____ ☐ Date Specific:_____

CLAIM TYPE

☐ Commercial ☐ Disability ☐ General Liability ☐ Homeowners

☐ Long Term Care ☐ Pre-Employment ☐ Workers' Comp

SERVICES REQUESTED

☐ Activity/Alive & Well
☐ AOE/COE
☐ Background Investigation
☐ CDR
☐ Cell Phone Forensics
☐ Clinic Inspections|Surv
☐ Court Appearance.
☐ EDR
☐ Locate/Skip Trace
☐ Medical Canvass
☐ Medical Record Retrieval
☐ Process Service
☐ Social Media Only
☐ Statement/Interview
☐ Surveillance
☐ Unmanned Surveillance

☐ Other:_____

Statements/Interview: *Please check all that apply*

☐ Claimant
☐ Doctor
☐ Employer
☐ In Person
☐ Insured
☐ Recorded
☐ Telephonic
☐ Witness
☐ Written
☐ Other

Background: *Please check all that apply*

☐ Asset
☐ Bankruptcy
☐ Civil
☐ Comprehensive
☐ Criminal
☐ DMV
☐ Other

INVESTIGATION INSTRUCTIONS

Number of Days: _____ **Budget:** _____

Objectives/Comments
(Please provide any additional information, attach additional pages as needed)

_____

_____

CLIENT INFORMATION

Claim Number: _____
Claim Adjuster: _____
Company: _____
Address: _____
City/State/Zip: _____
Phone: _____
Email Address: _____
TPA: _____

Insured Name: _____
Address: _____
Contact/Phone: _____
Defense Counsel: _____
Attorney Phone: _____
Attorney Address: _____
City/State/Zip: _____
Copy to Counsel? ☐ Yes ☐ No

Bill: ☐ TPA ☐ Insurance ☐ Client ☐ Other: (List Details)_____

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CLAIMANT INFORMATION

Claimant:	_____	**Date of Birth:**	_____
Address:	_____	**SS#:**	_____
City/State/Zip:	_____	**Driver's Lic. #:**	_____
Phone:	_____	**Gender:**	
Description:	Hgt:____ Wgt:____ Hair:_____	**Represented:**	☐ Yes ☐ No
Ethnicity:	_____	**Date of Hire:**	_____
Occupation:	_____	**Date of Loss:**	_____
Type of Injury:	_____	**Injury Reported:**	_____
Restrictions:	_____	**Employer Info:**	_____

Significant other / Known relatives: _____

Social Media Links: _____

Prior Surveillance Conducted? ☐ Yes ☐ No

Deposition Taken? ☐ Yes ☐ No

Upcoming Calendar Dates (trial, depo, IME, etc.)? _____

PHYSICIAN INFORMATION

Medical Group:	_____	**Doctor:**	_____
Address:	_____	**Phone:**	_____
City/State/Zip:	_____	**Appt. Date/Time:**	_____

AOE/COE ASSIGNMENT INFORMATION

Was first report of injury completed?	☐ Yes ☐ No	**If "yes", please provide copy of same**
Is Employer Contact Information available?	☐ Yes ☐ No	**If "yes, please include below**
Name: **Telephone:**		**Email:**
Were claimant's full personal identifiers provided above (address, phone #, DOB, SS#, job title, etc.?	☐ Yes ☐ No	
Is Medical paperwork/documentation available?	☐ Yes ☐ No	**If "yes" please include with referral**
Is claimant represented by an attorney?	☐ Yes ☐ No	**If "yes", please provide Notice of Representation/Application for Adjudication**
Is there an Employer's Report of Occupational Injury or Illness (From: 5020)?	☐ Yes ☐ No	**If "yes", please provide with referral**
Adjuster Case File Notes (3 Point Contact Notes)	☐ Yes ☐ No	**If "yes", please provide Case File Notes**

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