ATLAS
CLAIMS INVESTIGATION

Referral Form

Referrals@AtlasClaimsInvestigation.com

Services Requested:

Rush? ☐

Due Date: _____

Quick Referral

Claims Examiner/Adjuster _____ Examiner Company _____

Claimant Name _____ Claim Number _____

Soc. Sec. # _____ Date of Injury _____

Investigation Instructions

Number of Days _____

Objectives / Comments
(Please provide any additional information) _____

Client Information

Claim Number _____ Employer _____

Claims Examiner _____ Employer Contact _____

Company _____ Employer Address _____

Address _____ City/ St / Zip _____

City/ St / Zip _____ Employer Phone: _____

Phone _____

Email _____

Copy to Counsel? **Yes** ☐ **No** ☐

Defense Counsel _____ Address _____

Attorney Name _____ City/ St/ Zip _____

Attorney Phone: _____

Office: (877) 805-9826 or (916) 873-1594

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Claimant Information

Represented? ◯ Yes ◯ No

Claimant

Address

City/ St / Zip

Phone

Height

Hair

Occupation

Date of Birth

SS#

DL#

Race

Date of Injury

Weight

Gender

◯ Male ◯ Female

Injury

Restrictions

Prior Surveillance Conducted? ☐ **Deposition Taken?** ☐

Upcoming Calendar Dates?

Physician Information

Claimant ☐ DQME ☐

Medical Group

Address

City/ St / Zip

Doctor

Phone

Appt. Date
Appt. Time

How would you like to receive updates? (Check all that apply)

☐ Email ☐ Phone Notes:

How would you like to receive report/invoice?

☐ Email ☐ Mail ☐ Delivery Notes:

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