Print Form

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DATE: _____

FROM: _____
(COMPANY NAME/BRANCH OFFICE)

_____
(CLAIMS EXAMINER)

_____
(CLAIMS EXAMINER'S DIRECT #)

LITIGATION REFERRAL SHEET

CLAIM NO	WCAB NO
INSURANCE COMPANY	SELF-INSURED
POLICY NUMBER	POLICY PERIODS
APPLICANT	DATE OF INJURY
AGE / OCCUPATION	EARNINGS
EMPLOYMENT TERMINATED	DATE TERMINATED
EMPLOYER (INCLUDE ADDRESS & PHONE NO.)	
T.D. PAID / RATE	
FROM / TO	
P.D. PAID / RATE	
FROM / TO	
ADDITIONAL ADVANCES	TOTAL MEDICAL PAID
DATE OF TRIAL / CONFERENCE / MISC	

SUGGESTED ISSUES (CHECK)

- ☐ **Employment**
- ☐ **Occupation**
- ☐ **Inj. (Nat. & Ext.)**
- ☐ **Inj. (AOE/COE)**
- ☐ **Ins. Coverage**
- ☐ **Earnings**
- ☐ **Temp. Disability**
- ☐ **Perm. Disability**
- ☐ **Subrogation**
- ☐ **Apportionment**
- ☐ **Fut. Med. Care**
- ☐ **Self-Proc. Care**
- ☐ **Jurisdiction**
- ☐ **Statute of Lim.**
- ☐ **Dependency**
- ☐ **Voc. Rehab**
- ☐ **Labor Relations**
- ☐ **Discrimination**

WORK IN PROGRESS (CHECK)

- ☐ **Index Check Run**
- ☐ **Med Rec Subpoenaed**
- ☐ **Empl Rec Solicited**
- ☐ **Payroll Rec Solicited**
- ☐ **Job Desc. Sollcited**
- ☐ **Statements Arranged**
- ☐ **Subrosa Arranged**
- ☐ **Delay Letter Sent**
- ☐ **Denial Letter Sent**
- ☐ **QRR Assigned**
- ☐ **Settlement Pending**

AUTHORITY TO SUBPOENA RECORDS
☐ YES ☐ NO

DEPO AUTHORITY
☐ YES ☐ NO

DEFENSE EXAM(S)
☐ SET ☐ CLAIMS WILL SET ☐ ATTORNEY MAY SET

COMMENTS AND RECOMMENDATIONS (INCLUDE SPECIAL INSTRUCTIONS/REPORTING REQUIREMENTS