NAKAMOTO | CHOU, LLP

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FROM: Your Name: ______________________________ Phone: ______________________

Company Name: ____

Address: ____

Insurance Carrier: ____

EMPLOYEE: ______________________ DOI: ______________ Claim # ______________

EMPLOYER: ______________________________ POLICY PERIOD ______________

APPLICANT'S ATTORNEY: ______________________________ ☐ NONE

PRIOR RELATED INJURIES: DOI: ______________________ ☐ APP. FILED ☐ STILL OPEN

CLAIM FORM FILED ON: ______________ APPLICATION FILED ON: ______________

DENIAL LETTER FILED ON: ______________ ANSWER FILED ON: ______________

OR DENIAL DUE DATE: ______________

BENEFITS PAID:

TD $ ______________ PERIODS ______________

VRTD $ ______________ PERIODS ______________

PD $ ______________ PERIODS ______________

MEDICAL EXPENSES $ ______________ VR EXPENSE $ ______________

WORKERS COMPENSATION ISSUES:

☐ 1. INJURY AOE-COE ☐ 5. EARNINGS ☐ 9. PAST MEDICAL ☐ 13. DEPENDENCY

☐ 2. EMPLOYMENT ☐ 6. TEMPORARY DISABILITY ☐ 10. FUTURE MEDICAL ☐ 14. PENALTIES (EXPLAIN BELOW)

☐ 3. OCCUPATION ☐ 7. PERMANENT DISABILITY ☐ 11. STATUTE OF LIMIT. ☐ 15. OTHER (EXPLAIN BELOW)

☐ 4. COVERAGE ☐ 8. APPORTIONMENT ☐ 12. JURISDICTION

REQUESTED ACTION:

ATTEND HEARING: ☐ YES ☐ NO IF YES, DATE ______________ TIME: ______________ PLACE ______________

DEPOSE APPLICANT: ☐ YES ☐ NO ☐ Need to Discuss ______________

SCHEDULE MEDICAL EXAM: ☐ YES ☐ NO ☐ PHYSICIAN ______________

SUBPOENA RECORDS: ☐ YES ☐ NO ☐ SOURCE ______________

COMMENTS: ____