Date of Loss: ____________________

Claim Number: ____________________

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

☐ Other:____

Statements/Interview: *Please check all that apply*

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

Background: *Please check all that apply*

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

INVESTIGATION INSTRUCTIONS

Number of Days:

Budget:

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

____

____

CLIENT INFORMATION

Claim Number:	________________	**Insured Name:**	________________
Claim Adjuster:	________________	**Address:**	________________
Company:	________________	**Contact/Phone:**	________________
Address:	________________	**Defense Counsel:**	________________
City/State/Zip:	________________	**Attorney Phone:**	________________
Phone:	________________	**Attorney Address:**	________________
Email Address:	________________	**City/State/Zip:**	________________
TPA:	________________	**Copy to Counsel?**	☐ **Yes** ☐ **No**

Bill: ☐ **TPA** ☐ **Insurance** ☐ **Client** ☐ **Other: (List Details)**____________________

1-855-225-6974
nypiassociates@gmail.com/service@nycpia.com
85 front street, Hempstead,11550

CLAIMANT INFORMATION

Claimant:	______________________	Date of Birth:	______________________
Address:	______________________	SS#:	______________________
City/State/Zip:	______________________	Driver's Lic. #:	______________________
Phone:	______________________	Gender:	☐ Male ☐ Female ☐ Other
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?	Deposition Taken?	Upcoming Calendar Dates (trial, depo, IME, etc.)?
☐ Yes ☐ No	☐ Yes ☐ No	______________________

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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