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A PARTNERSHIP OF PROFESSIONAL CORPORATIONS
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FILE TRANSMITTAL

TO: _____ COMPANY SENDING FILE: _____

CLAIMANT: _____ _____

DATE OF INJURY: _____ CLAIM NO.: _____

OCCUPATION: _____ TEMPORARY DISABILITY PAID: _____

INSURED: _____ WEEKLY RATE: _____

_____ PERIODS COVERED: _____

POLICY NUMBER: _____ _____

POLICY PERIOD: _____/_____/_____ through_____/_____/_____ PERMANENT DISABILITY PAID: _____

APPARENT ISSUES:

G INJURY AOE/COE	G TEMPORARY DIABILITY	G PERMANENT DISABILITY	G INSURANCE COVERAGE
G EMPLOYMENT	G OCCUPATION	G APPORTIONMENT	G EARNINGS
G NEED FOR MEDICAL TREATMENT	G MEDICAL-LEGAL COSTS	G SELF-PROCURED MEDICAL	G LIEN CLAIMS
G PROXIMATE CAUSE OF DEATH	G REHABILITATION	G SUBROGATION	G OTHER (EXPLAIN BELOW)

PENDING ACTION

G MEDICAL EXAM	G DEPOSITION NEEDED	G WAGE STATEMENT REQUESTED	G PERSONNEL FILE REQUESTED
G EMPLOYER STATEMENT	G INVESTIGATION	G OTHER (EXPLAIN BELOW)	

HEARING DATE:_____ DATE APPLICATION RECEIVED:_____

REMARKS AND
INSTRUCTIONS: _____

_____

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CORRESPONDENCE ALSO TO BE SENT TO: _____

DATE: _____ FROM: _____