

ALTMAN, BLITSTEIN & BLINDER

ATTORNEYS AT LAW
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:

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

PENDING ACTION

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> MEDICAL EXAM | <input type="checkbox"/> DEPOSITION NEEDED | <input type="checkbox"/> WAGE STATEMENT REQUESTED | <input type="checkbox"/> PERSONNEL FILE REQUESTED |
| <input type="checkbox"/> EMPLOYER STATEMENT | <input type="checkbox"/> INVESTIGATION | <input type="checkbox"/> OTHER (EXPLAIN BELOW) | |

HEARING DATE: _____ DATE APPLICATION RECEIVED: _____

REMARKS AND INSTRUCTIONS:

CORRESPONDENCE ALSO TO BE SENT

TO: _____

DATE: _____

FROM: _____