

RHI CLAIMS SUPPORT Investigations Referral Form Phone 800-603-9902 Fax 925-734-3405

RHI Case # _____ Client Clm # _____ Decision Date _____
Co Name/Adrs _____
Examiner _____ Phone _____
Email _____ Fax _____
Def. Atty _____
Def. Atty Phone _____

Adrs Report to ___ client ___ atty ___ insured _____ other
Mail Report to ___ client ___ atty ___ insured _____ other
Video to ___ client ___ atty ___ insured _____ other

Insured _____ Contact _____ Phone _____
Insured Adrs. _____

Claimant _____ DOB _____ SSN _____ Phone _____
Adrs _____
DOH _____ Job Title _____ DOI Injury Type _____
** Applicant Atty _____

Assignment: ___ AOE/COE ___ SURVEILLANCE ___ ACT CHECK ___ MED/DEPO P/U ___ LIABILITY
___ SUBROGATION ___ BACKGROUND _____ OTHER

AOE/COE-INTERVIEW: ___ EE ___ ER ___ SUP ___ COWORKERS ___ WITNESS _____ OTHER

OBTAIN: ___ MED AUTH ___ MED RCRDS ___ PERS FILE ___ POLICE _____ OTHER

SURVEILLANCE- # of Days ___ # of Hrs Specific Dates or Med/Depo _____

Description: Race _____ HT _____ Weight _____ Hair _____

Other _____

Vehicles _____

Adtl. Instructions _____

For internal use Investigator _____ Date Assigned _____ Due Date _____ Req by _____