



BEJARS INVESTIGATION SERVICES

TOLL FREE: 1-866-278-3055
FAX: 619-923-3233

REFERRAL FORM

Referral Date:	Due Date:	<input type="checkbox"/> RUSH
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SERVICES REQUESTED

<input type="checkbox"/> Sub Rosa	<input type="checkbox"/> ACE/COE*	<input type="checkbox"/> Liability	<input type="checkbox"/> Auto Theft Inv.	<input type="checkbox"/> Recorded Statements	<input type="checkbox"/> SIU Fraud	<input type="checkbox"/> Other
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***AOE/COE Interview:** Please select all that apply

<input type="checkbox"/> Claimant	<input type="checkbox"/> Medical Authorization	<input type="checkbox"/> WCAB Search
<input type="checkbox"/> Employer	<input type="checkbox"/> Medical Records	<input type="checkbox"/> Other
<input type="checkbox"/> Witnesses	<input type="checkbox"/> Personnel Records	

Background: Please check all that apply

<input type="checkbox"/> Bankruptcy	<input type="checkbox"/> Skip Trace
<input type="checkbox"/> Civil Search	<input type="checkbox"/> WCAB Search
<input type="checkbox"/> Criminal Search	<input type="checkbox"/> Police Report

CLIENT INFORMATION

Claim Number:	Employer Name:	Employer Address:	Employer Contact/Phone:
Claims Examiner:	Employer Address:	Defense Counsel:	Attorney Name/Phone:
Company:	Address:	City/St/Zip:	Copy to Counsel?
Address:			
City/St/Zip:			
Phone:			
Email Address:			

CLAIMANT INFORMATION

Claimant:	Date of Birth	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	Gender:	Social Security #	
City/St/Zip:	Cell:	Drivers License #	
Phone:	Ht: Wt: Hair: Race:	Represented:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Description:	DOI:		
Occupation:			
Injury:			
Restrictions:			
Prior Surveillance Conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Deposition Taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	Upcoming Calendar Date (trial, MSC, etc)?	

PHYSICIAN INFORMATION _____ Claimant _____ DQME

Medical Group:	Doctor:	Phone:
Address:	Phone:	Appt Date:
City/St/Zip:	Appt Date:	Appt Time:
	Appt Time:	

INVESTIGATION INSTRUCTIONS

Number of Days:	
Objectives/Comments: (Please provide any additional information)	

PLEASE FAX TO: 619-923-3233

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