REFERRAL FORM

APEX INVESTIGATION®

Toll Free: 888-900-2739
Toll Free Fax: 877-782-7672

Referral Date:	Due Date:	☐ RUSH

CLIENT INFORMATION

Claim Number:	
Claims Examiner:	
Company:	
Address:	
City / St / Zip:	
Phone:	
Email Address:	

ATTORNEY INFORMATION

Defense Counsel:	
Attorney Name & Phone:	
Address:	
City / St. / Zip:	
Copy to Counsel?	☐ Yes ☐ No

PHYSICIAN INFORMATION

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

CLAIMANT INFORMATION

Claimant:	
Address:	
City / St. / Zip:	
Phone:	Cell:
DOB / SSN:	
DOI & Injury:	
Restrictions:	
Description:	Hgt: Wgt: Hair: Race:
Drivers License:	
Gender:	☐ Male ☐ Female
Represented:	☐ Yes ☐ No
Employer Name:	
Employer Address:	
Employer Contact/ Phone:	
Claimant Occupation:	

SERVICES REQUESTED

☐ Sub Rosa: 1☐2☐3☐4☐days Circle the # of days	☐ Social Spy	☐ Liability	☐ AOE/COE	☐ Auto Theft	☐ SIU Fraud	☐ DMI

AOE/COE Interview: *Please check all that apply*

- ☐ Claimant
- ☐ Employer
- ☐ Witnesses
- ☐ Medical Authorization
- ☐ Medical Records
- ☐ Personnel Records
- ☐ EDEX Search
- ☐ Other

Background: Please check all that apply

- ☐ Bankruptcy
- ☐ Civil Search
- ☐ Criminal Search
- ☐ Court Records
- ☐ DMV Records
- ☐ Financial/Asset
- ☐ Skip Trace
- ☐ WCAB Search
- ☐ Police Report

INVESTIGATION INSTRUCTIONS

Objectives/Comments: (Please provide additional information)	