

Please return the form:
 Mail: PO Box 210, Centralia, WA 98531
 Fax: (360) 736-4802
 Please call us at (360) 736-1301 if you have any questions.

Potential Client Intake Form

Name:		Date:	
Address:		Claim Number:	
City, St, Zip:		Date of Injury:	
Primary Phone #:	Social Security #:		
Secondary Phone:	Date of Birth:		
Email:	Claim Status: Open <input type="checkbox"/> Closed <input type="checkbox"/>		
		Rejected <input type="checkbox"/> Reopening Denied <input type="checkbox"/>	
Do you have any other open or recently closed LNI claims? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Spouses Name:		May we discuss your claim with your spouse? Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of Dependents:
Employer:	Job Title:		
How long with employer:	Income before injury:		
Did employer provide any of the following benefits: Healthcare: <input type="checkbox"/> Vision: <input type="checkbox"/> Dental: <input type="checkbox"/> Do you still receive: Yes <input type="checkbox"/> No <input type="checkbox"/> If not, when did they terminate:		Did your income include any of the following: Regular Overtime: <input type="checkbox"/> Bonuses: <input type="checkbox"/> Shift differential: <input type="checkbox"/>	
Who is your claims manager:	Phone number:		
Are you currently receiving:	Time Loss: <input type="checkbox"/>	Social Security: <input type="checkbox"/>	Unemployment: <input type="checkbox"/>
Involved in Vocational Rehabilitation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Who is your VRC	
Have you received an order in the last 60 days that you need to protest and/or appeal?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of that order:	
What did that order do?			
Is your claim at the Board of Industrial Insurance Appeals? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Nature of Injury:			
Did this injury involve a Motor Vehicle Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Who is your attending physician?			
Other doctors who have treated you for this injury:			
If you claim is self-insured, who is the service company/third party administrator?			
How did you hear about us:			

Please briefly describe the issue(s) you would like us to review: