

Questionnaire to Adjuster

*Important: Have your legal counsel approve all questions before using this form.
Use this form as a guideline when contacting the adjuster about the status of a claim.*

Employee Information		Claim #
Name	Phone Number () -	
Employer	Social Security # - -	
Questions		
1. What is the employee's condition?		
2. Is this a serious injury that may require surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Has the employee returned to work (RTW)? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what is the estimated RTW date? ___ \ ___ \ ___		
4. What type of medical care is the employee currently receiving? How long is this expected to continue?		
5. If this is a sprain or pulled muscle, will it require physical therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
6. If this is a back injury, has employee been out of work for more than 2 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
7. Is there a history of prior injury to this area of the body? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If so, can we get the medical records? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Note: There may be a MRI or FCE documenting the worker's pre-injury state; it is particularly important that IMEs have all prior information.</i>		
8. Do we have report of injury from first treating physician (including Emergency Room records)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Does the employee see physicians for other medical problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If so, do we have any of those records? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Note: There may be useful, contributing information in these records.</i>		
10. What is the <i>normal</i> recovery period for this injury? What guidelines are used for this estimate?		
11. Do you have physical restrictions for the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, I will fax you our Work Ability Form .		
12. Is this case or the duration of the injury questionable? <input type="checkbox"/> Yes <input type="checkbox"/> No		

13. What needs to be done to get physical limitations?
14. Does the doctor know <Company Name> has a transitional duty program? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. What services is the claims administrator using on this case? (check all that apply) <input type="checkbox"/> NCM <input type="checkbox"/> FBCM <input type="checkbox"/> Surveillance <input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> Other (specify): _____
16. What type of documentation do you have from the doctor?
17. Is the doctor providing updates following all medical visits? <input type="checkbox"/> Yes <input type="checkbox"/> No
18. What factors are driving the cost of this claim?
19. Has the employee reached MMI? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? ____ \ ____ \ ____
20. When was the last doctor/IME appointment? (Indicate date and results)
21. When is the next doctor's appointment? (Indicate date and purpose)
22. Has investigation and CIB turned up any prior injuries/conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what?
23. Is the employee cooperating with you and the doctor? (Keeping appointments, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No Is he/she arrogant in conversations? <input type="checkbox"/> Yes <input type="checkbox"/> No
24. What is the next step?
25. Will you please email, by noon tomorrow, an action plan of the best way to rapidly resolve this case? <input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Interviewer

Signature

Date

Name of Adjuster

Signature

Date