WORKERS' COMPENSATION FRAUD & COMPLIANCE UNIT
CLAIM REFERRAL / INITIAL INFORMATION REPORT

HOTLINE/PO BOX _____ INVESTIGATOR _____ DATE/TIME _____

COMPLAINANT: _____ Phone: _____

Address: _____

Business Name/Position: _____

SUBJECT: _____

Address: _____

DESCRIPTION: HT: _____ WT: _____ Build: _____ Complexion: _____

Sex: _____ Mustache/Beard: _____ Hair: _____

Age: _____ Scar/Tattoo: _____ Glasses: _____

VEHICLE #1: Make/Yr: _____ Model: _____

Color: _____ Registration#: _____

ACTIVITY / ALLEGATION: _____

(Continued on back)

Submit to: **Department of Labor & Training**
Workers' Compensation Fraud Unit
P O Box 20190
Cranston, RI 02920-0942

Hot Line: **(401) 462-8100 (option #7)**
E-mail: **wcfraud@dlt.state.ri.us**

Side 2.....Claim Referral / Initial Information Report

CLAIMANT: DWC Claim No:_____ SSN: _____

Name: _____

Address: _____

City: _____ Telephone: _____

Date of Injury: _____

EMPLOYER: Name: _____

Address: _____

City: _____ Telephone: _____

INSURANCE CO: Name: _____

Telephone: _____ Extension: _____

Claim #: _____ Body Part(s): _____

Adjuster: _____ Extension: _____

INCAPACITY: 1st Incap. From: _____ To: _____
2nd Incap. From: _____ To: _____
3rd Incap. From: _____ To: _____

INFORMATION: Marital Status: _____ Dependents: _____

AWW: _____ Comp. Rate: _____

CLAIM STATUS: Open / Closed _____ Total/Partial: _____

Non-Pred/Date: _____ Term./Date: _____

MOA/Date: _____ Susp./Date: _____

Settlement/Date: _____ Decree (WCC#): _____

DATE OF BIRTH: _____

PREVIOUS INJURY: No / Yes DOI: _____ Claim#: _____

DOI: _____ Claim#: _____

WORKERS' COMPENSATION FRAUD PREVENTION UNIT
CLAIM REFERRAL / INITIAL INFORMATION REPORT

ACTIVITY/ALLEGATION - (Continued)