

**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#: _____

