

Case Transmittal Form

Short Caption, including first name:

[Claimant/Plaintiff(s)]

v.

[Insured/Defendant(s)/Respondent(s)]

Case Submitted by: _____ for Plaintiff Defendant Adjuster

Arbitrator/Mediator(s) Requested: _____

Mediation date/time desired: _____ **Are we holding a date? If yes, what date?** _____

Location: Metairie _____ Baton Rouge _____ Mandeville _____ Other _____

Have you **discussed mediation** with the other side? Yes _____ No _____ Notes: _____

Are there any **trial dates** or **time limitations**? _____ **If yes, what date?** _____

If no, **what time frame to schedule?** _____

How are the fees to be handled: Paid by Submitter _____ Split (Explain): _____ Other _____

Type of case:

- Personal Injury Property Damage Workers' Comp Products Liability Med. Malpractice
 Construction Maritime Commercial Domestic Other _____

Does this case, or any others at your firm, have any **lien issues** related to **Medicare/Medicaid, group/private health plans** (including **Class Actions**)? _____ If so, **we can help**. Please call us at 800 -443-7351, or use this referral form: [LRS referral form](#)

Parties Involved:

Plaintiff's Counsel:

Name: _____
Represents: _____
Phone No.: _____
Email: _____
Avail dates: _____

Plaintiff's Counsel:

Name: _____
Represents: _____
Phone No.: _____
Email: _____
Avail dates: _____

Defense Counsel:

Name: _____
Represents: _____
Phone No.: _____
Email: _____
Avail dates: _____

Adjuster:

Name: _____
Company: _____
Claim No.: _____
Phone No.: _____
Email: _____
Avail dates: _____

PLEASE FORWARD THIS FORM TO:

E-mail: resolutions@maps-adr.com

Website: <http://maps-adr.com>

PHONE: (504) 831-2141
TOLL (800) 443-7351

FAX: (504) 837-2566

PHONE: (225) 769-4553
TOLL FREE: (866) 769-4553

Additional Parties

Counsel:

Name: _____
Represents: _____
Phone No.: _____
Email: _____
Avail dates: _____

Adjuster:

Name: _____
Company: _____
Claim No.: _____
Phone No.: _____
Email: _____
Avail dates: _____

Counsel:

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Represents: _____
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