

**CAROLINA PAIN MANAGEMENT**

*A Division of Carolina Neurosurgery, P.A.*

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**Worker's Compensation Information**

\*\*\*This form **MUST** be filled out in full for us to file worker's compensation.  
Incomplete information will result in the patient being responsible for the bill.\*\*\*

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Employer's COMPLETE Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Injury: \_\_\_\_\_

To whom did you report this injury? \_\_\_\_\_

Who at your employer authorized services? \_\_\_\_\_

Worker's Compensation Insurance Carrier: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Claim Number: \_\_\_\_\_

Adjustor's Name: \_\_\_\_\_

Adjustor's Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Do you have a nurse case manager?            YES            NO

If so, what is their name? \_\_\_\_\_

What is their phone number? \_\_\_\_\_

What EXACTLY happened? \_\_\_\_\_  
\_\_\_\_\_