

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? _____
