WORKERS COMP INFORMATION FORM

****** It is the responsibility of the patient to obtain authorization for each visit. Not having approval to see our Doctors will result in the Patient be responsible for payment of their bill.**

Patient Name:____

Date of Injury: ___________________

Employer associated with this claim: _____________________________

Are you still employed there? Yes No

Work Comp Insurance Carrier Name: ____________________________

Claim number: ____

Address to mail claims:____

Adjustor Name:______________________ Phone #: _________________

Do you have legal representation? Yes No

Name of your Attorney: __________________

Law Firm he is with: ______________________

Law Firm's phone #:______________________

Has a claim been filed with the IWCC? Yes No

Patient Signature _______________________

Date: