WORKMEN'S COMPENSATION FORM

PATIENT NAME:_____
DOB:_____

EMPLOYER:_____
PHONE #:_____

WC INSURANCE CARRIER:_____

DATE OF INJURY:_____
CLAIM/FILE #:_____

ADJUSTER'S NAME:_____
PHONE #:_____

HAS THIS BEEN ACCEPTED AS A WC INJURY? YES_____ NO_____

PLEASE NOTE THAT THE ABOVE INFORMATION MUST BE RECEIVED AND UNTIL THEN YOU WILL BE HELD TOTALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO YOU. ONCE THE INFORMATION IS RECEIVED AND CONFIRMED YOU ARE NOT HELD RESPONSIBLE.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER THAT RENDERED SERVICES.

Signature:_____**Date:**_____