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LETTER OF INFORMATION OF WORKER'S COMPENSATION CLAIM

PATIENT NAME: _____ SSN#_____

Date of Birth:_____ Telephone #:_____

Address: _____

STREET CITY STATE ZIP

Email:_____

EMPLOYER NAME: _____

Address:_____

STREET CITY STATE ZIP

Telephone #_____ Contact Person: _____

WORKER'S COMPENSATION CARRIER: _____

Work Comp Address:_____

Case Manager/Contact Person:_____ CLAIM #:_____

Case Manager/Contact Person Phone# _____

BODY PART INJURED: _____

- **DATE OF INJURY**: _____
- COUNTY OF INJURY? _____
- IS THIS CASE IN DISPUTE? YES___ NO___
- **HAS YOUR EMPLOYER BEEN NOTIFIED**? YES_____ NO_____
- HAS A FORM100 BEEN FILED BY YOUR EMPLOYER? YES___ NO___
- CAN WE OBTAIN A COPY FOR OUR FILES? YES___ NO___
- HAS YOUR EMPLOYER OR YOUR WORKER'S COMPENSATION CARRIER AUTHORIZED YOU TO SEE US? YES__ NO__

DO YOU HAVE AN ATTORNEY? YES___ NO___ (IF YES PLEASE SUPPLY THE FOLLOWING INFORMATION TO US)

Attorney Name:_____ Telephone #:_____

Attorney Address:_____

STREET CITY STATE ZIP

HEALTH INSURANCE INFORMATION, IN CASE OF SUBROGATION (WE WILL FIRST BILL YOUR WORKER'S COMPENSATION INSURANCE IF WE HAVE ALL THE CORRECT INFORMATION

- INSURANCE NAME:_____
- ADDRESS:_____

STREET CITY STATE ZIP

- POLICY NUMBER(S):_____
- SUBSCRIBER NAME:_____

PATIENT SIGNATURE: _____DATE:_____