

WORKER'S COMPENSATION CLAIM

HAVE YOU FILED A WORKER'S COMPENSATION FORM? YES NO

HAS YOUR CLAIM BEEN ACCEPTED? YES NO

WORKER'S COMPENSATION CARRIER: _____

ADDRESS: _____ PHONE: (____) _____
STREET CITY STATE ZIP

CLAIM #: _____ CLAIM ADJUSTER: _____

HAVE YOU RETAINED AN ATTORNEY? YES NO

ATTORNEY NAME: _____ PHONE #: (____) _____

ADDRESS: _____
STREET CITY STATE ZIP

PLEASE NOTIFY OUR OFFICE SHOULD YOU AQUIRE AN ATTORNEY FOR THIS INJURY AS THE PATIENT/GUARDIAN IS SOLELY RESPONSIBLE FOR ALL INFORMATION REGARDING THIS CLAIM.

HOW DID YOU CHOOSE OUR FACILITY?

REFERRED BY: FRIEND FAMILY M.D. OTHER _____

THANK YOU.