

# WORKER'S COMPENSATION FORM

DOES YOUR EMPLOYER KNOW YOU ARE HERE TODAY? \_\_\_NO\_\_\_ YES

PATIENT NAME \_\_\_\_\_ SSN# \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ CLAIM # \_\_\_\_\_

## **EMPLOYER INFORMATION**

SUPERVISOR'S NAME \_\_\_\_\_

EMPLOYER'S NAME \_\_\_\_\_

EMPLOYER'S PHONE NUMBER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

## **WORKER'S COMPENSATION CARRIER INFORMATION**

W/C INSURANCE CARRIER: \_\_\_\_\_

W/C ADDRESS \_\_\_\_\_

W/C CITY: \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

W/C PHONE \_\_\_\_\_

W/C FAX \_\_\_\_\_

W/C CLAIM REPRESENTATIVE NAME \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

NURSE CASE MANAGER \_\_\_\_\_

COMPANY NAME \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

**FOR OFFICE USE ONLY:**

**AUTHORIZATION FOR PROCEDURES**

**DATE /APPROVED BY**

_____	_____
_____	_____
_____	_____
_____	_____