WORKER'S COMPENSATION

Patient's Information:

First Name:_____MI:_____Last Name: _____

SSN_____Date of Injury:_____Injury: (Body part)_____

Location (City & State) Where Injury Occurred: _____

Send Work Comp Claims to:

Work Comp Carrier Name: _____

Mailing Address: _____

City:_____State:_____Zip:_____

Phone #: (_____)_____-_____ Fax #: (_____)_____-_____

Claim #:_____ Electronic Payer ID_____ Electronic Docs w/ claims? Y N

Adjustor's Name:_____ Send Docs? Y N

Phone #: (___)_____-_____ Fax #: (_____)_____-_____

Nurse Case Manager:_____ Send Docs? Y N

Phone #: (___)_____-_____ Fax #: (_____)_____-_____

Notes: _____

_____

_____

Patient's Attorney Information (if applicable):

Phone: (_____)_____-_____

Attorney Name: _____

Firm Name:_____

Address:_____

City:_____State:_____Zip:_____

Case # (IWCC #) Filed with State of Illinois:_____WC _____

Complete this section with the employer information at the time of injury

Employer Name: _____

Employer Address: _____

City:_____State:_____Zip:_____

Work Phone: (_____)_____-_____