Workers Comp Form

Chart# ____________

Patient Name ______________________ ______________________ ______________________
LAST FIRST MIDDLE

DOB ______________ SSN # ______________________ Male ________ Female ________

EMPLOYER INFORMATION

Company Name ____

Address ____

______________________ ______________________ ______________________
CITY STATE ZIP

Phone # ______________________ Fax # ______________________

WORKERS COMP INSURANCE INFORMATION FOR BILLING CLAIMS

The information below must be filled out before seeing you as a patient here at Powell Orthopedics, P.A. We will need this information in order to file your claims. We may need to forward this insurance information to the Hospital, Physical Therapist, MRI or Durable Medical Equipment Company, if needed, so they may also file your claims.

Name of Workers Comp Ins. Company ____

Mailing Address ____
STREET, P.O. BOX AND OR SUITE #

______________________ ______________________ ______________________
CITY STATE ZIP

(1) Adjuster ____

Phone # ______________________ Fax # ______________________

(2) Nurse Case Mgr. ____

Phone # ______________________ Fax # ______________________

Claim # ______________________ Date of Injury ______________________

What part of your body did you injure and how? ______________________

____

____ Date ______________
SIGNATURE OF PATIENT

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