WORKER'S COMPENSATION INSURANCE INFORMATION

PATIENT NAME: **DOB:**

INJURY DATE/TIME: **VISIT DATE:**

DOES THE PATIENT HAVE AUTHORIZATION TO BE SEEN? YES NO

AUTHORIZING PERSON/SUPERVISOR:

AUTHORIZER/SUPERVISOR PHONE #:

EMPLOYER NAME:

EMPLOYER ADDRESS:

EMPLOYER PHONE #:

EMPLOYER FAX#:

DOES THE EMPLOYER WANT A DRUG SCREEN PERFORMED? YES NO

WHO IS PAYING FOR THE DRUG SCREEN? PUT IN AS SECONDARY PAYOR

DOES THE EMPLOYER WANT TO PAY FOR THE VISIT THEMSELVES? YES NO

IF **NO**, THEY MUST SUPPLY US WITH THE FOLLOWING INFORMATION:

WC INSURANCE CARRIER:

CLAIM #:

INSURANCE BILLING ADDRESS:

ADJUSTER'S NAME:

ADJUSTER'S PHONE #: ADJUSTER'S FAX #:

IF **YES**, THEY MUST SUPPLY US WITH THE FOLLOWING INFORMATION:

CONTACT PERSON FOR BILLING:

ADDRESS FOR BILLING:

PHONE # FOR BILLING: FAX # FOR BILLING: