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***

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