

Workers Compensation Information Form



Grand Haven
Bone & Joint

Patient name _____

Date of injury _____

Patient birthdate _____

If exact date of injury is unknown, provide the date your injury was reported.

Social Security # _____

Employer name _____

Employer phone # _____

Employer address _____

Who should we contact at your place of employment regarding this treatment?

If known, who is the workers compensation carrier? Do you have their address and/or phone number?

Carrier Claim number:

Who should we contact at the workers compensation carrier regarding this injury and treatment?

Have you been under the care of any other physician for this injury? ____

If so, please provide the physicians name:

To your knowledge, is this claim in dispute, or are there any problems with this claim?

Do you have an attorney involved? ____ If so, please provide attorney's name and address:

If this claim is disputed or rejected by workers compensation, you will be responsible for all charges. In order to submit a claim for you, we must have your authorization to release medical information to your employer and/or workers compensation carrier. I hereby authorize release of information necessary to file a claim for payment of my bills under workers compensation.

Signature _____

Date _____