

WORKERS' COMPENSATION CLAIM

You must report your accident in order for our office to submit a claim

Patient

Name: _____

Social Security Number: _____

Employer (at time of injury)

Name: _____

Address: _____

Phone Number: _____

On the date of injury/illness what was your job description?

On the date of injury/illness what was your usual work activities?

Workers' Compensation Insurance Carrier

Name: _____

Address: _____

Phone Number: _____

Claim Number: _____

Case Manager/Adjustor

Name: _____

Phone Number: _____

Fax Number: _____

WCB Number: _____

Date of Injury: _____ Type of injury/body part? _____

Signature

Date