Workers' Compensation Case Information Form

Section A: Patient Information

Last Name:		First Name:
Date of Birth:	SSN:	Date of Injury:

Section B: Workers' Compensation Claim Information

In the space below, please provide a narrative of how your injury occurred. If additional space is needed, please use the back side of this page.

Insurance Information			
Insurance Company:		Claim#:	
Adjuster/Name of Contact Person (at Insurance Company):			
Phone#:	Fax#:		
Address:	City	State:	Zip:

Employer Information			
Company Name:	Contact Person/HR:		
Phone#:	Fax#:		
Address:	City	State:	Zip:
What is your job title?			

Case Management Information
A. Have you been contacted by a Nurse Case Manager regarding your care? ☐ **YES** ☐ **NO** **If yes, please complete questions below.**
B. Did the Nurse Case Manager contact you prior to scheduling your appointment with this office? ☐ **YES** ☐ **NO**
C. Has your Nurse Case Manager directed you in any way to any facility or physician? ☐ **YES** ☐ **NO**

Nurse Case Manager Contact Information	
Name:	Company:
Phone#:	Fax#:

1. **Have you signed a retainer for legal representation? ☐ YES ☐ NO If YES, please complete section D.**

Section D: Attorney Information

Law Firm Name:			
Attorney Name:	Assistant Name (If applicable):		
Phone#:	Fax#:		
Address:	City	State:	Zip:

All information submitted on this form is true to the best of my knowledge. I understand any incorrect information submitted may result in a delay of my treatment. It is my responsibility to submit any changes to my claim information in a timely manner. I understand that I am financially responsible for all charges of services rendered to me including the balances of claims denied by my Worker's Compensation Insurance Company, Third Party Payer and/or attorney.

____ ________________________

Signature Date