Worker's Compensation Form

Date of Exam: _____

Name: _____ **Date of Birth:** _____

Address: _____

Phone #: (_____) _____-_____ **Employer:** _____

Worker's Comp. Carrier: _____

Carrier's Billing Address: _____

_____

Worker's Comp claim number		☐ Not available
Patient's condition related to	Employment	◉ Yes ○ No
	Auto accident	○ Yes ○ No
	Other accident	○ Yes ○ No
	Another party responsible	○ Yes ○ No
Case injury date		
Injured body part		
Description of injury		

Highlighted fields **MUST** be completed in order for us to bill your claim.

Adjuster last name		for reference only
Adjuster first name		for reference only
Adjuster phone/contact info		for reference only
Adjuster fax		for reference only
Repricer name		for reference only
Repricer phone/contact info		for reference only
State		▼ State in which the first report of injury is filed. If US Department of Labor, select state in which the patient's employer is lo
Accepted diagnoses Enter . for lookup	ICD-9	
	Acceptable diagnosis codes as specified by patient's carrier	
	ICD-10	
	Acceptable diagnosis codes as specified by patient's carrier	