# Workers Compensation Administrative Demographics

All patients wishing to file claims through their employer's workers compensation plan must have their employers human resource personnel complete this form. Please submit completed form prior to their first appointment.

**COMPANY INFORMATION-**

NAME OF EMPLOYER:

INSURANCE CO PROVIDING WORKERS COMPANSATION AND MAILING ADDRESS ***FOR ALL MEDICAL CLAIMS:***

NAME

STREET

CITY ST ZIPCODE

PHONE#

FAX#

POLICY/CONTRACT#:

**CASE WORKERS NAME AND CONTACT INFORMATION:**

NAME

STREET

CITY ST ZIPCODE

PHONE#

FAX#

EMAIL ADDRESS

**EMPLOYEES NAME AND CONTACT INFORMATION:**

NAME

DATE OF BIRTH

SSN ***(REQUIRED)***

LIST INJURY AND NATURE OF ACCIDENT

DATE OF INJURY

CLAIMAINT ID (CLAIM #)

**AUTHORIZATION SERVICES:** Depending on the nature of the accident our provider many find the need to perform balancing and or hearing diagnostic testing in addition to the consult visit with MD.

DO WE HAVE AUTHORIZATION TO CONSULT AND TREAT? ☐ YES ☐ NO

WHO PROVIDES ADDITIONAL AUTHORIZATION IF NEEDED?

ANY ADDITIONAL INFORMATION OR RESTRICTION WE SHOULD KNOW ABOUT

**NAME OF PERSON WHO COMPLETE THIS FORM & PHONE #:**