Worker's Compensation INSURANCE VERIFICATION

Please fill out completely. If we do not get this information by your second visit, you will be expected to begin paying towards your balance. If you have any questions about the status of insurance payments, please don't hesitate to ask.

Name:_____ Date of birth:_____

Case Number:_____

Have you reported the injury to your supervisor? YES NO

Name & Address of Employer:_____

_____

_____

Work Supervisor: _____

Contact Number:_____

Name of Work Comp Insurance:_____

Phone number for insurance:_____

Contact phone number for medical providers: _____

To be filled out by office staff Date received: _____

Insurance contacted:

Date: _____ Name of contact: _____

Has this insurance accepted responsibility for the claim? YES NO

Can we get that sent to us in a letter or fax:_____

Do medical notes need to be sent with claims? YES NO

Address to mail claims to:

_____

_____

_____

_____

Is electronic billing available? YES NO If so, EDI Payor # for claims: _____

Other notes:_____

_____

_____