ORTHOPAEDIC ASSOCIATES of Wisconsin

There is a Difference.

WORKER'S COMPENSATION INFORMATION FORM

PATIENT INFORMATION:

PATIENT LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ GENDER: M F SOCIAL SECURITY # _____

EMPLOYER INFORMATION:

NAME/LOCATION OF EMPLOYER WHERE INJURY OCCURRED: _____

EMPLOYMENT STATUS: FULL TIME PART TIME SELF-EMPLOYED OTHER: _____

HR DEPT / NAME OF PERSON TO OBTAIN WORK COMP AND PHONE # _____

WORK COMP INSURANCE NAME: _____

ADJUSTER NAME / PHONE NUMBER: _____

WORK COMP CLAIM NUMBER: _____

INJURY INFORMATION:

DATE OF INJURY: _____ BODY PART: _____

WAS THE INJURY REPORTED TO THE EMPLOYER? YES NO

WERE YOU TREATED ELSEWHERE FOR THIS INJURY? YES NO

IF YES, WHERE: _____

DESCRIBE HOW THE INJURY OCCURRED: _____

_____

PERSONAL HEALTH INSURANCE INFORMATION:

NAME OF PERSONAL HEALTH INSURANCE CARRIER: _____

ID # _____ GROUP # _____

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

Please be advised that we will bill your personal insurance carrier if the Work Comp carrier denies your claim. It is your responsibility to provide Orthopedic Associates of Wisconsin billing department all updated information that you receive regarding either your Workman's Compensation coverage or any changes to your personal insurance.

Signature of Patient: _____ Date: _____