WORKERS COMPENSATION FORM

It is the patient's responsibility to provide Parkview Medical Clinic the following information. ***If this form is not filled out completely, the patient will be held responsible for the all charges.***

Please note if this information is incomplete or inaccurate, Parkview Medical Clinic will not be able to process the claim. ***Please also note that work comp claims tend to have a timely filing period of 6 months (meaning the sooner you get us this information, the easier it will be to process). Failure to provide this information timely will result in the bill being the patient's responsibility.***

At the time of each visit, the patient must make Parkview Medical Clinic aware of which visit(s) should be billed to workers compensation or automobile insurance, and which should be billed to their health insurance plan.

PATIENT NAME:____

DATE OF BIRTH: __________________

EMPLOYER NAME: ____

NAME OF HR REP: _____________________________________

HR REP PHONE #: _________________________

DATE OF INJURY: ____

TYPE OF INJURY (i.e. hand, knee, back, etc.): _______________________________________

WC INSURANCE COMPANY: ____

WC INSURANCE ADJUSTER NAME: ____

WC INSURANCE ADDRESS: ____

____

WC INSURANCE ADJUSTER PHONE #: __________________________

WC CLAIM #: __________________

FIRST DATE OF SERVICE FOR INJURY AT PARKVIEW: ________________

DOCTOR FOR WC SERVICE AT PARKVIEW: __________________________