Worker's Compensation Information

Initial app't date: _____ Time: _____

Location: _____ Dr.: _____

Patient's name: (First) _____ (MI) ____ (Last) _____

Date of birth: _____ SS#:_____ Phone: _____

Address: _____

Employer:_____ Employer Contact: _____

Employer's phone: _____ Employer's Fax: _____

Carrier/TPA: _____

Billing Address: _____

Adj's Name: _____ Claim #: _____

Adj's phone _____ Ext. _____ Adj's Fax: _____

Date of Injury/Onset: _____ Referral Type: Please check all that apply:

_____ Evaluate & Treat _____ IME _____ Hand Chart

_____ Take-Over Care _____ Records Review _____ Surgery

_____ Causation Opinion _____ PPI Rating _____

Mechanism of injury_____

_____

Compensable body part(s): _____

Issues: _____

_____

Case Manager:

Name: _____ Company: _____

Phone: _____ Fax: _____

Sender's name: _____ Adjuster Case Manager Employer Other

Please return by fax to (317) 249-2618

Scheduled by: _____ Date: _____