WORKERS' COMPENSATION INSURANCE INFORMATION

PATIENT: ___________________________MRN:________________
DOB: ________________
Date of Injury______________

1. **Employers Workers' Compensation Insurance Company (Not Personal Medical Health Insurance):**

   a. **WC Ins Name: ____**

   b. **WC Claims Address:_______________________________________**

   ____

   c. **WC Claims Phone Number:___________________________________**

2. **Claim Number** for ***CURRENT INJURY :*** ________________________________

3. **Name of Claims Adjuster:______________________________________**

4. **Employer:____**

5. **H.R. Phone Number:____**

Please speak to the person at your place of employment who manages the workers' compensation to obtain this information.

When completed you may fax this form to ________ or mail to:

Reliant Medical Group
____
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For questions please call:

Delay in providing this information may result in receiving bills for services provided.