WORKER'S COMPENSATION INFORMATION

*Name:*____*Date:*______________________

*Social Security Number:*__________________________________*(needed for claim verification)*

Thank you for choosing to treat at The Orthopaedic Institute of Western Kentucky. Please complete this form and answer all questions accurately. This information is required in order to bill and provide records to appropriate contacts. If you have not filed a claim with your employer, you should do so immediately. Authorization is pending, unless you have been notified otherwise.

*Employer Name (Where were you injured?) :*____

*Are you still employed with this company?*____

*Employer Address:*____

*Employer Supervisor or H.R. Contact:*____

*Employer Phone #:*________________________*Employer Fax #:*____________________________

Employer Work Comp Insurance Name: _________________*Claim#:*___________________________

*Insurance Adjustor/Contact Name:*_____________________ *Phone/Fax #:*________________________

*Have you completed an accident report with your employer?*_____________________________________

*Was your Supervisor or other Contact notified at the time of the accident?*____________________________

*What is the date and time the injury occurred?*____

*Did the injury occur while you were on your lunch break?*_______________________________________

*How did this accident happen?*____

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*What body part or parts are affected?*____

*Have you missed work due to this injury?*____________*When was the last day you worked?*______________

*Are you presently working?*______________*When was your first day back to work?*___________________

*Are you working light or restricted duty?*____

*Have you seen another physician for this injury, briefly describe*___________________________________

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*Do you have an attorney? If yes, please provide his or her name.*___________________________________

*Is your claim denied or disputed/in litigation for any reason?*_____________________________________

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If your claim is not accepted or payment is denied, you may be responsible for charges incurred. Private insurance may or may not pay for services if the injury or symptom is reported as work related. Our facility prefers not to bill your private insurance unless a written denial is received.

*Patient Signature:*____________________________________*Date:*____________