Worker's Compensation Verification

Patient Acct#:

Section 1 - Patient Data

Injured Worker's Name:____________________ Date of Birth:____________________

SS#____________________ Date of Injury: ____________________

Section 2 - Employer Information

Employer: ____________________ Phone:____________________

Address:____________________ City____________________State__________Zip__________

Is the Company Self-Insured?____________________

Supervisor:____________________ Was Injury Reported? Y / N

Reported to Whom?____________________ Reported on What Date:____________________

Has Claim been filed with carrier?____________________ Claim #____________________

Authorized By:____________________Date:__________ Denied By:____________________Date:__________

Person Spoke with:____________________Date:______/_____ /______ Time ____________________

Verified By:____________________

Section 3 -Work Comp Carrier

Insurance Carrier:____________________Phone:____________________

Address:____________________ City____________________State__________Zip__________

Adjuster:____________________ Direct Phone #____________________ext.__________

Adjuster e-mail:____________________

Claim #:____________________ Policy #:____________________

Authorized By:____________________Date:__________ Denied By:____________________Date:__________

Denial Reason:____________________

____

Special Instructions:____________________

____

____

Require Notes Sent With Claim? Y / N

Person Spoke with:____________________Date:______/_____ /______ Time ____________________

Verified By:____________________

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