Today's Date / Initials ______________________

Appt Date / Provider ______________________

Account #

WORKERS COMPENSATION VERIFICATION SHEET

Insurance Set #

Patient Information

Person giving Information

Patient Name		Home Phone #	
Address		Date of Birth	
City/State/Zip Code		*** Social Security # ***	
Personal Insurance		Pt refused to give Ins info	☐
HMO referral requested	☐	DOL letter requested	☐

Work Injury Information

Person giving Information

Date of Injury		Body Part Injured	
Employer		Work Phone #	
Work Address		City/State/Zip Code	

Workers Compensation Insurance Information

Person giving Information

Insurance Company			
Mailing Address		Telephone Number	
City/State/Zip Code		Fax Number	
Claim Number		Adjuster	

Managed Care Company

Person giving Information

Company Name		Telephone Number	
Contact Name		Fax Number	

COMMENTS: ______________________

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Date Called:
Employer:

Patient ______________________
WC Carrier: ______________________