WORKMAN'S COMPENSATION INJURY INSURANCE FORM

If you have been injuried on the job, this injury must be reported to your employer in order to have the claim paid. In the State of Pennsylvania, if your employer has a ***Panel of Physicians***, you are required to be treated by a physician on that panel for the first 90 days following the reported injury. You must confirm with your employer that ***our doctors*** are on the Panel of Physicians, if applicable, assigned by your employer before beginning treatment.

Patient Name:____

Address:____

City:__________________________State:______________________Zip:__________________

Phone:___________________________

Employer Name*:*____

Address:____

City:_________________________State:_______________________Zip:___________________

Phone: _______________________Relationship to Patient:______________________________

Workman's Comp Insurance Company:____

Address for Claims:____

City:_________________________State:_______________________Zip:___________________

Phone:___________________________Claim Adjuster:___________________________________

Claim #:_______________________________Date of Injury:_______________________________

Occupational Injury Report: _______YES ________NO

I certify that the information I have reported with regard to my insurance coverage is correct.

SIGNATURE:____DATE:__________________________

If this information is not provided at time of service, you will be responsible for the office visit until the information is provided to our billing department, 610-269-1372, ext. 120.