WORK COMP INTAKE FORM

PHYSICIAN:_____ PATIENT NAME: _____

CLAIMS ADJUSTER

NAME:_____ CO. NAME: _____

PHONE #: _____ FAX #: _____

EMAIL: _____

NURSE CASE MANAGER

NAME: _____ CO. NAME: _____

PHONE #: _____ FAX #: _____

EMAIL: _____

EMPLOYER

NAME:_____ PHONE #: _____

CONTACT NAME: _____

OCCUPATION: _____

CAN EMPLOYER ACCOMMODATE RESTRICTIONS:_____

INJURY DETAILS

DOI:_____DESCRIPTION:_____

APPROVED AREA(S) TO TREAT: _____

BILLING INFORMATION

INS CO. NAME: _____ CLAIM #: _____

CLAIMS ADDRESS: _____ PHONE # FOR CLAIMS:_____

VENDORS

DME CO.:_____ PHONE: _____

MRI CO: _____ PHONE: _____

PT/OT CO: _____ PHONE:_____