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PATIENT WORK INJURY REPORT

Our office will use this report to contact your employer to verify that a work injury claim has been filed. Until a claim has been filed with your employer, worker's compensation will not process any medical bills for payment. If you have questions or problems with your work injury claim, you may contact The Wisconsin Department of Workforce Development.

TODAY'S DATE:

*Indicates required field to be completed by patient

PATIENT'S FULL NAME*	PATIENT'S HEALTH INSURANCE CARRIER*	DATE OF INJURY*
CHIEF COMPLAINT(S)*	DESCRIBE HOW YOU WERE INJURED*	
EMPLOYER'S NAME*	EMPLOYER CONTACT NAME * (Human Resources and/or Supervisor)	EMPLOYER'S PHONE NUMBER*
EMPLOYER'S ADDRESS*		
	WORKER'S COMPENSATION INSURANCE CARRIER *	CLAIM NUMBER *
INSURANCE ADJUSTER'S NAME	CLAIMS MAILING ADDRESS	ADJUSTER'S PHONE NUMBER
ADDITIONAL INFORMATION		

I AUTHORIZE SUBMISSION OF ALL BILLS TO MY EMPLOYER OR WORKER'S COMPENSATION CARRIER. IN COMPLIANCE WITH WORKER'S COMPENSATION GUIDELINES, I UNDERSTAND THAT ALL RECORDS PERTAINING TO CARE WILL BE SUBMITTED AS WELL. I FURTHER UNDERSTAND THAT UNTIL WORKER'S COMPENSATION ACCEPTS LIABILITY, I AM RESPONSIBLE FOR ALL CHARGES.

PATIENT SIGNATURE: ________________________________ **DATE:** ____________

INTERNAL USE ONLY:
CLAIM INFORMATION WAS VERIFIED BY: ______________________ **ON:** ______________