WORKER'S COMPENSATION CLAIM INFORMATION

NAME_____ DATE_____

SOCIAL SECURITY NUMBER_____ DATE OF LOSS_____

EMPLOYER:

COMPANY NAME_____ TELEPHONE _____

SUPERVISOR_____

HAVE YOU REPORTED THIS INJURY? YES NO REPORTED TO_____

HAVE YOU COMPLETED AN INCIDENT OR ACCIDENT REPORT? YES NO

HAVE YOU CONSULTED ANOTHER HEALTH CARE PROVIDER FOR THIS INJURY? YES NO

CARRIER:

INSURANCE COMPANY NAME_____ TELEPHONE _____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

IF YOU ARE ALSO COVERED BY HEALTH INSURANCE BENEFITS, PLEASE COMPLETE:

INSURANCE CO NAME_____ TELEPHONE_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

INSURED NAME_____ ID#_____ GROUP#_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR PAYMENT OF CHARGES INCURRED IN THE EVENT MY WORKER'S COMPENSATION CLAIM IS DENIED. I AUTHORIZE THE BILLING OF HEALTH INSURANCE IF BENEFITS ARE AVAILABLE AND ASSIGN PAYMENT TO: *BRONSTON CHIROPRACTIC CLINIC.*

_____ _____

SIGNATURE DATE

ARE YOU REPRESENTED BY AN ATTORNEY? YES NO IF YES, PLEASE COMPLETE THE FOLLOWING?

ATTORNEY NAME_____ TELEPHONE _____

ADDRESS_____

CITY_____ STATE_____ ZIP_____