LANCASTER MEDICAL WORKERS' COMPENSATION INFORMATION

PLEASE FILL IN THE FOLLOWING INFORMATION COMPLETELY: Date:_____

PATIENT INFORMATION

Name:_____
Date of birth:_____ Social Security #:_____
Address:_____ City:_____ State:____ Zip:_____

EMPLOYMENT INFORMATION

Employer:_____ Telephone:_____
Address:_____ City:_____ State:____ Zip:_____
Job title:_____ Usual work activities:_____
_____

INJURY INFORMATION

Date of Injury:_____ Time injury occurred:_____ AM/PM
Date reported to employer:_____ Name of person who took accident report:_____
Type/Location of Injury:_____
Brief description of how injury occurred:_____
_____
Location where injury occurred (if different than above employer address):_____
_____
Have you lost any time from work due to injury?_____ If yes, what dates:_____
Do you have any previous Workers' Compensation injuries?_____ If yes, please explain:_____
Have you ever had the same or similar injury?_____ If yes, what dates:_____
Have you seen another physician for this condition?_____ If yes, Doctors Name:_____

EMPLOYER'S WORKERS' COMPENSATION INSURANCE INFORMATION
In the event that the following information is not furnished completely, the charges will be mailed to you directly. We cannot bill your primary insurance carrier for work related injuries.

Carrier Name:_____
Carrier Address:_____
City:_____ State:_____ Zip:_____
Carrier Phone Number:_____ Carrier Case Number:_____
WCB Case Number:_____

AUTHORIZATION

I hereby assign, transfer, and set over to Lancaster Medical all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

In the event I fail to prosecute the claim for Workers' Compensation for this illness or condition or it is determined by the Workers' Compensation board that the illness or condition is not a result of a compensable Workers' Compensation case, I hereby agree to pay my physician/medical group their usual and customary fees for services rendered to the above name claimant in the above identified case.

Signature:_____ Date:_____