Workers Compensation Information

Eligibility Sheet

Patient Information:

Patient Name:____

Patient Account # (WH):____________________Date of Birth__________________________________

Date of Injury/Accident:____________________ Primary Care Physician:________________________

Employer Information:

Patient's Employer:____

Employer Address:____

Company Contact:____

Phone Number:______________________________Fax:____

Insurance Information:

Workers Compensation Insurance Carrier:____

Address: ____

Insurance Case Worker:____

Phone:______________________________________Fax:_______________________________________

Authorization Number: ____

Employer Representative Authorizing Visit:______________________________ Date: ___________

All information must be filled out in order to file your claim.