WORKER'S COMPENSATION INFORMATION

The following information is required for submitting work-related injury claims to your worker's compensation insurance company. If you are unable to complete this information, any charges incurred will be your responsibility until such time as the information is received. **FYI: You will receive a statement from us each month until your worker's compensation insurance company has started to pay your claim.**

Please complete this form and return it to:

Fall General Surgery
216 Third Street West, Suite 201
Ashland, WI 54806
(715) 685-0656
Fax: (715) 685-9326

Date:____________________

Name:____

Address:____
Mailing Address City, State Zip

Date of Birth:____________________ Social Security #:______________________________

Date of Injury/Illness:_______________________________

How did Injury/Illness occur:____

____

____

Has your employer been notified of injury and when? ______________________________

If you have been off work, please list dates:_____________________________________

Do you have other Work Comp injuries?____

WE NEED THE FULL MAILING ADDRESS OF YOUR EMPLOYER

Employer Name:____

Human Resource Contact: ____

Address:____
Mailing Address City, State Zip

Telephone Number:_______________________________

NAME OF EMPLOYER'S WORKER'S COMPENSATION COMPANY

If you are unsure of this information, please bring to your employer to fill in.

Insurance Company Name:____

Address:____
Mailing Address City, State Zip

Telephone Number:_______________________________

Claim Number:_______________________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the release of medical information and/or copies of my health record to the above Worker's Compensation Insurance Company.

Date:____________________ Signed:____