NORTHERN INDIANA HAND & WRIST CENTER

WORKERS COMPENSATION INFORMATION FORM
****This form to be filled out by *employer* prior to appointment****

Employee Name: ____ **DOB:** __________________

Injury Type: ____ **DOI:** __________________

Employee Soc #: ____ □ **Male** □ **Female**

Adjuster: ____ **Claim #** __________________

Employer Information:

Name: ___________________________________

Address:

____

____

Tel / Fax: ________________________________

Insurance Carrier Information

Name: ___________________________________

Address:

____

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Tel / Fax: ________________________________

Authorized By: ____ **Date:** ____________________

Employer Signature

Patient Please Note: **Workers Compensation form *will be verified prior* to your being seen by the doctor. Ultimate financial responsibility lies with you if workers compensation denies or discontinues coverage for any reason. Any amounts unpaid by work comp carrier after 60 days from date of service require full payment by patient. Please acknowledge your acceptance of this information by signing below.**

Signature: ____ **Date:** __________________________

Created: September 2011