workers' compensation information sheet

INITIAL VISIT ONLY

Employee Information

Employee name: ______________________ DOB: __________ Today's date: __________

Injury date: __________ In what state did the injury occur?: ______________________

What part of your body is injured?: ______________________ ☐ Right ☐ Left Both

Have you been seen elsewhere for this injury?: ______________________

If yes, please complete the medical record release form.

Employer Information

Employer name: ______________________ DER/Company contact: ______________________

Address: ______________________ City: __________ State: ______ Zip: ______

Phone: ______________________ Ext. __________ Secure fax: ______________________

Treatment authorized by: ______________________ Title: ______________________

Post-Accident Drug and or Alcohol Testing Required: Yes ☐ No ☐

If yes, please complete EHS Authorization form.

Workers' Comp Billing Information

WC Insurance carrier: ______________________

Address: ______________________ City: __________ State: ______ Zip: ______

Phone: ______________________ Fax: __________ Policy #: ______________________

Claim #: ______________________

Adjuster name: ______________________ Adjuster phone: ______________________

Internal Use Only:

Form reviewed for completion by: ______________________ Date: __________

Based on your state specific workers' compensation billing rules and regulations, all charges are being billed to:

☐ Employer ☐ Work Comp Carrier ☐ Employee

Profile printed and reviewed: Yes ☐ No ☐ If no, create EHSNet profile: Yes ☐ No ☐

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