WC Claim Information

Please complete this form in its entirety. The requested information is REQUIRED in order to obtain payment for your treatment. ***We will be unable to provide services today if any information is missing.***

PATIENT DEMOGRAPHICS

Name: _____ **Suffix:** Jr. Sr. II III
First Middle Last

Patient's SSN: _____-_____-_____ **Sex:** M F **Birthdate:** _____/_____/_____ **Age:** _____

EMPLOYER DEMOGRAPHICS

Employer: _____

Employer Address: _____
Street City State Zip

Employer's Phone: _____ **HR/Risk Management Contact:** _____

INSURANCE

Worker's Compensation Carrier: _____

Claim Number: _____ **Date of Injury:** _____/_____/_____

Adjuster: _____ **Phone:** _____ **Ext:** _____

Nurse Case Manager: _____ **Phone:** _____ **Ext:** _____

TREATMENT HISTORY

Have you had any previous treatment for your current condition? *YES NO* ***If YES, where:***

Provider: _____ **Phone:** _____

California insurance regulations require that Worker's Compensation be billed as the primary insurance for all work related claims. I understand that knowingly withholding or falsifying information is a violation of the law. I understand that I will be financially liable for any services rendered which are not covered or paid by my worker's compensation claim(s). The above information is true and correct to the best of my knowledge. Should any of the information pertaining to my claim or care change, I will notify Physical Therapy Specialists without delay at (805) 473-7499.

_____ _____
Signature of Patient Date