MIDWEST NEUROSURGERY ASSOCIATES, P.A. ***WORKERS COMPENSATION CLAIM***

Name_____ **Date** _____

HAS THIS VISIT BEEN AUTHORIZED BY YOUR WORKERS COMPENSATION CARRIER? _____

Employer Information

Employer_____ **Employer Phone #**_____

Employer's Address _____

Person to contact at your employer_____ **Phone#**_____

Workers Compensation Insurance Carrier

Name of insurer_____ **Phone#** _____

Address_____

Contact person_____**CLAIM #** _____

Date of injury_____ **First date of disability** _____

How were you injured? _____

_____

Have you had previous treatment for this injury? _____ **If yes, when and where?** _____

_____

Previous x-rays?_____ **CAT scan?** _____ **MRI scan?** _____

Referring physicians name _____

Attorney's name _____ **Phone** _____

I authorize the release of medical information to my workers compensation insurance carrier. I understand that if my consultation or treatment has not been approved, I will be responsible for the charges.

_____

Signature **Date**