



**MULTICARE HEALTH CENTER**

3840 SOUTH HARLEM AVENUE

LYONS, IL 60543

**P: 708.442.3050 | F: 708.442.3058**

# WORKER COMPENSATION INFORMATION

Date \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_

Cell Phone \_\_\_\_\_ Occupation \_\_\_\_\_

## EMPLOYER INFORMATION

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Phone \_\_\_\_\_ Injury Verified by (for Office use) \_\_\_\_\_

Contact Person \_\_\_\_\_ Claim Number \_\_\_\_\_

## WORKER COMPENSATION CARRIER (for office use)

Worker Compensation Carrier \_\_\_\_\_

Carrier Address \_\_\_\_\_

Carrier Phone \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Coverage Verified by \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Claim Number \_\_\_\_\_

## INJURY INFORMATION

Date of Injury \_\_\_\_\_ Time \_\_\_\_\_ AM  PM  Place of Injury \_\_\_\_\_

Accident reported to employer? Yes  No  Name of person you reported to \_\_\_\_\_

Give full description of how accident happened \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you lost time from work? Yes  No  How Much? \_\_\_\_\_

Other doctor seen for this condition Doctor's Name \_\_\_\_\_

Diagnosis \_\_\_\_\_ Were X-rays taken? Yes  No  Other test? Yes  No

If yes, by whom? Please list test(s) and result(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any previous Worker Compensation injuries? Yes  No  Date(s) of previous injuries \_\_\_\_\_

Describe previous Worker Compensation injuries \_\_\_\_\_

## AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that i am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filling for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient