Work related injury

We need the following information to bill your account for medical treatment related to a worker's compensation injury. If this claim is not approved, or is taken to litigation at a later time, you will be financially responsible to Apple Family Medicine, PLC for the services.

*__Note__: Your health Insurance will not cover a work-related injury.

Patients Name: _______________________________________ **DOB**:_____________

Employer: ____

Employer Address: ____

City, State and Zip Code: ____

Phone Number: ____________________ Fax Number: _______________________

Was the injury reported? YES NO

If yes, to whom? _______________________________

What is the date of the above injury? ________________________

Work Comp Ins Co:____

Address: ____

City, State and Zip Code: ____

Claim Number: _________________________________

Adjustor Name ____________________________ Phone #:_____________________

I understand that if the Worker's Compensation carrier and employer do not pay on this claim, I am responsible to pay for services rendered.

Signature_________________________________ Date_________________________