

Workers' Compensation Accident/ Injury Insurance Information Form

After completing the document, please return form via mail within 7 days.

Name: _____
Phone number: _____
Date of Birth: _____
Last 4 of Social Security Number: _____
Date Of Service: _____
Medical Record #: _____
Guarantor #: _____

Date of Injury: _____
Type of Injury/ Body Part Injured (Be Specific): _____
State Accident Occurred In: MN WI ND MI
Other (Please Specify What State): _____

****To Ensure proper processing of the charges related to this injury, please check one or more of the applicable boxes listed below****

- I did have a Workers' Comp injury (Complete Section A)
 I did not have a Workers' Comp injury (Complete Section B)
 I am self-employed & do not have a workers' compensation insurance. (Complete Section B)

- This worker's compensation claim is pending with my attorney. (Complete Section B)
Attorney's Name: _____
Attorney's Number: _____
 This is not a work-related injury. (Complete Section B)
 Other (Please Specify): _____

Section A: Workers' Compensation Insurance to be billed for this accident: (Obtain Information from Employer)

Insurance Company Name: _____
Address: _____ City: _____
State: _____ Zip: _____
Phone: _____
Claim Number: _____

Policy Number: _____
Claim Adjuster's Name: _____
Claim Adjuster's Fax: _____
Claim Adjuster's Phone: _____

Employment Information at the Time of Injury:

Employer's Name: _____
Address: _____

City: _____
State: _____ Zip: _____
Phone: _____

Section B: Primary Health Insurance Billing Information

Insurance Company: _____
Claim Mailing Address: _____
City: _____ State: _____
Zip: _____ Phone: _____
Effective Date of Policy: _____

Name of Subscriber: _____
Relationship to Patient: _____
Policy ID Number: _____
Group Number: _____

Secondary Health Insurance Billing Information:

Insurance Company: _____
Claim Mailing Address: _____
City: _____ State: _____
Zip: _____ Phone: _____
Effective Date of Policy: _____

Name of Subscriber: _____
Relationship to Patient: _____
Policy ID Number: _____
Group Number: _____

I hereby authorize Duluth Family Medicine Clinic to release information and medical records to the Workers' Compensation insurance company listed for the payment of all related medical services regarding the Date of Injury above. Should Worker's Compensation deny payment for the claims, we will submit the denial and a new bill to your health insurance carrier.

Print Name: _____ Signature: _____
Phone: _____ Date: _____

*Form may also be mailed/Faxed to the following: Duluth Family Medicine Clinic
330 N 8th Ave E
Duluth, MN 55805
Phone: 218-723-1112
Fax: 218-529-9129