WORKER'S COMPENSATION INFORMATION

The following information is required for submitting work-related injury claims to your worker's compensation insurance company. If you are unable to complete this information, any charges incurred will be your responsibility until the information is received.

Please complete this form and return to:

Fogarty Surgical Services
11128 N State Highway 77
Hayward, WI 54843
Phone: (715) 934-3124 Fax: (715) 934-3125

Patient Information

Date:_____ Social Security #:_____

Name:_____ DOB:_____

Address:_____
Street/Mailing Address City, State Zip

Injury Information

Date of Injury:_____

How did injury occur:_____

_____

_____

If you have been off work, please list dates:_____

Do you have other Work Comp injuries?_____

Employer Information

Employer:_____ Telephone number:_____

Complete Address:_____
Street/Mailing Address City, State Zip

Worker's Compensation Insurance Company Information

Work-Comp Insurance Company:_____

Address:_____
Street/Mailing Address City, State Zip

Telephone Number:_____ Case Worker:_____

Claim Number:_____

Authorization for Release of Medical Information

I authorize the release of medical information and/or copies of my health record to the above Worker's Compensation Insurance Company.

Date:_____ Signed:_____