

## 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: \_\_\_\_\_