Work Comp Verification Form

Date:_____ Dr:_____

Patient in office:_____ Date/Time of Appointment:_____

Patient:_____Date of Birth:_____

SS#: _____

Chief Complaint:_____

Accident: (Include body areas affected, force, weights, detailed description of incident): _____

_____

_____

_____

_____

Date of Injury:_____ Supervisor Name: _____

Is date if injury within 2 weeks of appointment date? ____yes ____no (pre authorize any physical medicine)

Employer Name: _____

Employer Address (City, St, Zip)_____

Phone Number: _____ Fax Number: _____

Ask the patient to bring a copy of E-1 Report - pay attention to the injury area reported by the employer

Accident verified with Employer _____ Yes ____ No E-1 Report filed with carrier ____ Yes ____ No

TWCC 73 form received from Provider ____ Yes ____ No

Employer Address: _____

City, St. Zip: _____

Employer is _____TDI _____Certified Network _____Self Insured _____Self Insured Network

(if a network are you a treating doctor in that network?) (ask self insured if they follow DWC rules)

Insurance Company: _____

Claims Address:_____

City,St.Zip: _____

Phone Number: _____ Fax Number: _____

Claim Number: _____

Pre Auth Company _____

Phone Number _____ Fax Number _____

Insurance Rresentative/Adjuster:_____

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