1101 Twin C Lane
Suite 203
Newark, DE 19713
302-633-1280
Fax: 302-633-1284

Workers' Compensation / Auto Liability Injury Form

In an effort to accurately and efficiently send your claim to your insurance company, we need the following information to be filled out to the best of your knowledge:

Please check one: ☐ Workers' Compensation ☐ Auto Injury

Date of Injury: ____________________

Patient Name: ____

Patient Date of Birth: ___________________________

State where accident / injury occurred: __________

Insurance Carrier Name: ____

Claim Number: ____

Claims Mailing Address: ____

____

Insurance Carrier Phone Number: ____

Claims Adjuster Name: ____

Claims Adjuster Phone Number: ____

In addition, we will need to forward medical records to your worker's compensation insurance / auto insurance carrier. By signing this form, you are allowing us to release records to any Workman's Compensation carrier or attorney involved in your case in order to obtain payment for your claim. Please be aware that you are ultimately responsible for your charges. Any claims not paid by insurance within 30 days will be forwarded to you for payment.

____ ____________________

Patient Name (Please Print) **Date of Birth**

____ ____________________

Signature of Patient or Patient Representative **Date**