LINCOLN INTERNAL MEDICINE

Workman's Compensation Form

ALL FIELDS MUST BE FILLED OUT FOR ACCURATE BILLING

Patient Information **Date of Injury:** _____

Name: _____ Date of Exam: _____

Date of Birth: _____ Phone Number: _____

Patient Address: _____
Street

_____
City State Zip Code

Employer Information

Employer Name: _____

Employer Number: _____

Employer Address: _____
Street

_____
City State Zip Code

Workman's Compensation Information

Workman's Comp Carrier: _____

Workman's Comp Claim#: _____

Billing Address: _____
Street

_____
City State Zip Code

Adjuster Information:

Adjuster's Full Name: _____

Adjuster's Phone Number: _____ Fax Number: _____

State (in which the first report of injury is filed): _____

Condition Related Information:

The condition is related to: Employment: ☐ Yes ☐ No Auto Accident: ☐ Yes ☐ No

Another PartyResponsible: ☐ Yes ☐ No Other Accident: ☐ Yes ☐ No

Body Part Injured: _____

Description of Injury: _____

_____

_____

_____