WINDERMERE
Medical Center

Primary Care | Walk-in Care | Chiropractic Care

WORKER’S COMPENSATION VISIT

You are being seen in our office today due to an injury you sustained at your place of employment. We need the following information to process your claim:

Today’s Date: _________________ Date of Accident: _____________________

Name: ______________________________ Date of Birth: ______________

Employer: ___________________________ Contact Name: _______________________

Employer Phone/Fax: _____________________ / _____________________

Employer Address: ____

Claim Number: ____

Confirmation: __________ (Staff Initials)

PAYMENT POLICY

Accurate information must be provided in order for us to verify the status of your claim. If we are unable to reach your adjustor or a representative, you will be charged our self-pay rates for your visit. We will reimburse you once we are able to verify your claim status.

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