WORKER COMPENSATION INFORMATION

Patient Name:
Attending Physician:
Date of Birth:
Medical Records Number:
Claim Number:

Good Samaritan Medical Group Specialists
3219 Central Ave, Ste. 200
Kearney, NE 68847
Phone (308)865-2370
Fax (308)865-2843

Good Samaritan Medical Group Orthopaedic Surgery/Sports Med
3219 Central Ave, Ste 102
Kearney, NE 68847
Phone: (308) 865-2600
Fax: (308) 865-2838

EMPLOYER

Name: _____
Employer Address: _____
_____
_____
Employer Telephone: _____ Injury Verified By (for office use)_____
Contact Person: _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Work Compensation Carrier _____
Carrier Address _____
_____
Carrier Phone Number _____ Coverage Verified by _____
Adjuster's Name _____ Claim # _____

INJURY INFORMATION

Date of Injury _____ Time _____ am pm
Place of Injury _____
Accident reported to employer? Yes No Name of person you reported to: _____
Give full description of how accident happened _____
_____
_____
_____
_____
_____
Have you lost time from work? Yes No How much? _____
Date Last Worked _____
Other doctors seen from this condition:
Doctor's Name _____
Were X-rays taken? Yes No Other test? Yes No
If yes, by whom? Please list test(s) and result(s)
_____
_____
_____
Any previous Worker Compensation injuries? Yes No
Date(s) of previous injuries _____
Describe previous Worker Compensation injuries _____
_____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied.

Patient's Signature: _____ Date: _____