

Patient name: _____ Date: _____

AUTO OR WORKER'S COMP INFORMATION FORM

Is this a worker's comp claim? _____ (If yes, please fill out information below)

Employer: _____ Employer #:() _____

Employer Address: _____
Street City State

Worker's Comp Carrier Name: _____ Phone#:() _____

Carrier's Address: _____
Street City State

Claim #: _____ Date Of Injury: _____

Adjuster Name: _____ Adjuster's #:() _____

Accident details: _____

Is this an auto claim? _____ (If yes, please fill out information below)

Auto Insurance Carrier : _____ Phone#:() _____

Auto Insurance Address: _____
Street City State

Policyholder's Name: _____ Phone#:() _____

Claim #: _____ Date Of Accident: _____

Adjuster Name: _____ Adjuster's #:() _____

Accident details: _____

Oculoplastic Consultants of Central Pennsylvania will file your worker's comp and/or auto claims, however if benefits are terminated, exhausted and/or non-applicable you will be responsible for all charges incurred. We also ask that you keep us updated if there are any changes to your claim.

Patient/guardian signature: _____ Date: _____