Hand to Shoulder Center of Wisconsin

Worker's Compensation/Third Party Form

PLEASE PRINT CLEARLY WITH BLUE OR BLACK INK Appointment Date_____

Last Name_____Jr II III First Name_____M.I._____

Date of Birth_____SS#_____

If you are filing a Worker's Compensation claim or a Third Party Liability claim, we request completion of the appropriate section below.

WORKER'S COMPENSATION CLAIM INFORMATION

IMPORTANT - Worker's Compensation Claim

Please contact your employer for accurate billing information ***BEFORE*** your appointment with our specialist to avoid receiving a billing statement. Also, if your health insurance is an HMO or requires an authorization to be seen by a specialist, we strongly suggest contacting your primary care physician to obtain a referral prior to your appointment for the best benefits available to you in case your Worker's Compensation claim is denied.

Date of Injury_____State Accident Occurred In_____

Employer Responsible for Injury_____

Address_____Plant # (if applicable)_____

City_____State_____Phone #_____

Worker's Compensation Insurance Carrier Information

Insurance Carrier's Name_____Phone #_____

Claims mailing address or PO Box _____

City_____State_____Zip Code _____

Claim #_____Adjustor_____

THIRD PARTY LIABILITY CLAIM INFORMATION

IMPORTANT - Third Party Liability Claim

Please contact the responsible party for accurate billing information ***BEFORE*** your appointment with our specialist to avoid receiving a billing statement. Also, if your health insurance is an HMO or requires an authorization to be seen by a specialist, we strongly suggest contacting your primary care physician to obtain a referral prior to your appointment for the best benefits available to you in case your Third Party Liability claim is denied or exhausted.

Date of Injury_____State Accident Occurred In_____

Type of Third Party Liability Accident? Auto_____ Home Owner's_____ Other_____

Third Party Liability Company Insurance Carrier Information

Insurance Carrier's Name_____Phone #_____

Claims mailing address or PO Box_____

City_____State_____Zip Code_____

Claim #_____Adjustor_____

Insured Name_____Date of Birth_____