Community Eye Care Specialists

Workers Compensation

Patient Name: _____ DOB: _____

Date of Injury: _____ Time: _____

Type of Injury: _____

Auto or Non Auto: _____

Patient Employer at time of injury: _____

Employer Contact: _____

Employer Phone Number: _____

Workers Comp Carrier: _____

Claim Number: _____

Name of Comp Insurance Adjuster: _____

Phone Number for Comp Adjuster: _____

Alternate private Insurance: _____

Attorney's name and number if applicable: _____

Authorization for treatment: _____

All information must be filled out and an authorization obtained from the workers comp insurance before the patient is seen