DuPage Medical Group

WE CARE FOR YOU

Patient Label

MRN: _____

Pt Name: _____

Date of Birth: _____

Workers' Compensation

If your illness or injury is related to your work, your company carries insurance to pay your medical bills. Please complete this form so that your claim is filed with your company properly. If you agree to a settlement under the Workers' Compensation Act, be sure that your medical bills have been included in the settlement.

If your claims are denied under the Workers' Compensation Act, you will become fully responsible for payment.

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Employer Information

Company Name at Time of Injury: _____

Contact Name: _____ Contact Title: _____

Contact Telephone Number: _____

Injury Details

Date of Injury: _____

Type of Injury: _____

Body Part(s) Involved: _____

Claim Information

If the following information is unknown at the time of the appointment, please contact your employer for the required information and contact our Customer Service Department at 630-942-7998 within five (5) business days. Failure to provide this information may result in any balance from your visit becoming your responsibility.

Responsible Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Claim Number: _____ Claim Adjuster: _____

I hereby authorize DuPage Medical Group to release to my employer, Workers' Compensation representative, or their designees, any information which may be requested concerning my condition or treatment.

_____ _____

Signature of Patient or Legal Representative **Date**

Relationship to Patient: _____