

Worker's Compensation Insurance

Insurance Carrier: _____

Claim Number #: _____ Date of Injury: _____

Adjuster Name: _____ Phone Number: _____

Claims Billing Address: _____

City *State* *Zip*

Occupation at time of injury: _____

Employer at time of injury: _____

Employer's Address: _____

City *State* *Zip*

What happened?: _____

Where did it happen?: _____

Is an attorney involved? **Yes** **No**

(If so, please list the name and phone number of attorney currently working your case)

Name: _____ Phone #: _____

Is your claim: **Closed** **Open** **Litigation** **Palliative Care Only**

(please circle)