WORKERS COMPENSATION
INSURANCE VERIFICATION

Todays Date:____________

Patient Name:______________________________

Claim #:__________________________________

DOI (Date of Injury):________________________

Insurance co.:____

Adjuster Name & Ext.:____________________________________

Tel no.:______________________________

Fax no.:______________________________

Has the claim been approved? (Verify then that the claim is open and active.)____

Address to send claims:___________________________________

____

Verified by:_____________