THE MED STATION
WALK-IN MEDICAL CARE
Primary and Urgent Care for Children & Adults
PRIMARY CARE ● URGENT CARE ● FAMILY PRACTICE

WORKER'S COMPENSATION

Patient Name: _____

Social Security # _____
(Necessary for Worker's Comp claim)

Employer Name: _____
(Necessary for Worker's Comp claim)

Employer Address: _____

_____

Employer Phone #: _____

Contact Name: _____
(ie. manager, supervisor, HR department)

Worker's Comp Insurance Name: _____

Insurance Address: _____

_____

Insurance Phone: _____

Adjuster's Name: _____

Case / Claim #_____

Date of Accident / Injury: _____

Job Title / Description: _____

- Leaving out any information will delay the process of your claim. Please fillout as much as possible.