WORKERS COMP INFORMATION FORM

THIS FORM MUST BE COMPLETED **IN FULL** IF YOU ARE BEING SEEN FOR A WORKERS COMPENSATION INJURY

ORTHOPEDIC ASSOCIATES OF SW OHIO

Patient Name: _____Social Security # _____-_____-____ Day Phone (____) ____-_____ Ext: _____

What was your place of employment when you were injured? _____

What was your occupation when you were injured? _____

Employer address:_____

City, State, Zip:_____

Employer phone # (____) ____ -_____ Contact/HR Person:_____

BWC Claim or SSN: _____ Date of Injury: (MUST HAVE TO FILE BWC CLAIM): ____/____/_____

Have you been able to work since the first day of injury? YES ☐ or NO ☐

If no, please provide the date you last worked? _____

Have you completed a First Report of Injury (FROI)? YES ☐ or NO ☐

If you have not filed this form, please ask to speak with our BWC personnel.

Managed Care Organization (MCO) or Self-Insured Company: _____

Body part injured – please also indicate right or left: _____

Allowed condition(s) on claim: _____

Please give a **detailed description of how your injury occurred (do NOT use 'at work' or similar statements):

_____

_____

Check one: ☐ My on-the-job accident was the one and only cause of my present condition.

☐ My on-the-job accident aggravated a condition that already existed prior to my accident.

Private Insurance Information: Company: _____ ID# _____

Do you have an attorney, if so please provide:

Attorney Name: _____

Attorney address: _____ City, State, Zip:_____

Please fill out medical release for attorney on the back side of this form**

If this is a new injury we do **REQUIRE all prior testing to be provided to us.**

_____

Patient Signature **Date**

A copy of your private insurance card is needed for your file. It will be used only if your Workers Compensation claim is denied. If you private insurance carrier requires a referral, you should inform your Primary Care Physician of this fact and ask that your chart be noted. By following these steps, if your claim is denied, the referral may be obtained.