Paul H. Deutsch M.D., R.Ph., LLC
86 New London Turnpike Norwich, CT 06360
Phone: 860 889-6967 Fax: 860 885-1033

WORKERS COMPENSATION FORM

EMPLOYEE

Name _____

D.O.B. _____

Address _____

City/Town _____

Zip Code_____ Tel. #_____

PERSONAL INSURANCE INFORMATION

Primary Insurance _____

Subscriber Name _____

D.O.B. _____

Relationship to Subscriber _____

ID# _____

Secondary Insurance _____

Subscriber Name _____

D.O.B. _____

Relationship to Subscriber _____

ID# _____

EMPLOYER

Name _____Tel. #_____

Address _____

City/Town _____State_____Zip_____

INJURY

Date of Injury_____

City/Town of Injury_____

State _____ Zip Code_____

Body Part(s) _____

Cause of Injury_____

_____

Reported to Employer on _____

Revised 10/3/13

INSURER

Workers Compensation Insurance Carrier

_____

Address _____

City/Town _____State_____

Zip Code _____

Claim Number _____

Claim Representative _____

Tel. #_____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

_____

PATIENT SIGNATURE

IF THE WORKERS COMPENSATION CARRIER DENIES THIS CLAIM, I AM RESPONSIBLE FOR PAYMENT OF THESE SERVICES AND FOR ALL COSTS. THEREFORE, I AUTHORIZE THE PAYMENT FOR SERVICES RENDERED BY PAUL H DEUTSCH, M.D. RPH. DIRECTLY TO HIM BY MY INSURANCE FOR COSTS DENIED BY THIS WORKERS COMPENSATION CLAIM.

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_____

_____PATIENT SIGNATURE