

CAPITAL MEDICAL CLINIC, LLP

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Workman's Compensation Billing Information

In order for us to file your Workman's Compensation claim, you must provide all necessary information as listed below. If the information is not provided in 2 days, we reserve the right to bill you for all services.

NAME _____ Date of Birth _____

Address _____ Home Phone _____

City/State/Zip _____ SSN _____

Injury Claim # _____ Date of Injury _____

Brief Description of Injury _____

EMPLOYER _____ Work# _____

Address _____ City _____ State _____ Zip _____

Contact Person _____ Contact# _____

SUBMIT CLAIMS TO _____

Address _____ City _____ State _____ Zip _____

Contact Person _____ Contact# _____

NAME OF LAWYER (if applicable) _____

Address _____ Phone _____

HEALTH INSURANCE _____ ID# _____

- I understand that Capital Medical Clinic will file claims on my behalf.
- I authorize the release of any medical information necessary to process my claims.
- I understand that I am responsible for payment of all services provided to me by this clinic.
- If I am unable to provide all necessary information at this time, I agree to provide it within 2 days of this appointment.
- **Signature** _____ **Date** _____