Capital Medical Clinic
4701 Normal Blvd Lincoln, Nebraska 68506
Phone 402-488-5050 Fax 402-488-5001

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_____

(Revised 05/2014)