WORKER'S COMPENSATION/DOT CLAIM FORM

Employee Name: ____ **Date of Birth:** __________________

Employer: ____

Address: ____

Contact Person: _________________________________ Phone Number: __________________________

(Please select one option)

Date of Injury:	Date of DOT/CDL Physical:
Injury Sustained:	

______________ Bill Employer

___________ Bill Worker's Compensation Insurance
(If billing 3rd party, please complete below)

Insurance Co. Name:________________________________ Address:_________________________________

Phone Number:____________________________ Name of Contact Person:_____________________________

Claim Number:_________________________

Please be advised that by completing this form you are authorizing us to treat the above employee for the injury sustained. All related charges for this injury will be billed to the employer address unless otherwise instructed. Payment is due within 60 days and if no payment is received, responsibility of the charges will become the patient's.

If you have any questions, please feel free to contact our patient accounts department at (231) 348-3808. Please sign, date and fax this form to (231) 347-2020. Thank you.

Signed: ____ Date: ___________________________

Printed Name: ____