SAN JOSE NEUROSPINE

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WORK-RELATED INJURY REPORT FORM

1 Universal injury or accident statement

Last Name _____ First Name _____ MI _____ Today's Date _____

Please complete the following statement. Most insurance companies request accident details and this may be forwarded with your insurance claim or provided to an adjuster to complete your claim. Please complete the sections that apply to your injury and sign at the bottom of the form.

Dateofinjury_____

Place where injury occurred (work, home, parking lot, car, friend's house, etc.) _____

2 Please describe how the injury or accident occurred

_____

_____

_____

3 Work related injury

Was the injury work related? ☐ Yes ☐ No (If yes, complete this section)

Name of Employer _____

Telephone # _____

Employer's Address _____

City _____ State _____ Zip _____

Workman's Compensation Carrier _____

Policy # _____ Group # _____

Claims Address _____

City _____ State _____ Zip _____

4 Third party liability settlement

Is there a possible third party liability settlement? (e.g., auto, homeowners, property)

☐ Yes ☐ No (If yes, complete this section)

Name of Insurance _____

Telephone # _____

Adjuster's Name (if known)_____

Telephone # _____

5 Authorization

I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury and the nature of the treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred.

Patient Name (or signature of responsible party) _____ Today's Date _____