

WORK-RELATED INJURY REPORT FORM

Last Name MI Today's Date	Universal injury or accident statement	
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. Detectifying:		
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	Authorization	
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 reduest 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		To day de Donte
Patient Name (or signature of responsible party) Today's Date COPYRIGHT © 2017 Prizm Development, Inc.		