MMI Workers' Compensation Information Form

Dear Patient,

You have indicated to us that you were involved in a work related injury. Before a Workers' Compensation claim can be filed on your behalf, we **MUST** have the following information immediately. If you did not come with this information, please feel free to use our courtesy telephone in the waiting room to contact your employer. This information must be obtained before your scheduled appointment time today. In the event that you miss your scheduled time, but do receive this information and the doctor is still here, every effort will be made to see you sometime during patient care hours. However, if you are unable to obtain this information, it will be necessary for you to reschedule your appointment. Obtaining this information is **YOUR** responsibility.

Employer's Name:_____

Address:_____

Contact Person:_____ Phone Number:_____

Date of Injury:_____ Time of Injury:_____

Has a First Report of Injury been done? ○Y ○N Did you bring a copy? ○Y ○N

We must receive a copy of the first report within 48 hours.

Workers' Compensation Carrier:_____

Address:_____

Phone Number:_____ Extension:_____

Claim/Case Number:_____ Contact Person:_____

Describe what happened to cause your injury:_____

I, _____ authorize MMI to apply for benefits on my behalf for all services rendered. I further authorize the release of all medical information necessary to process my claims. I understand that in the event that my Workers' Compensation claim is denied or I fail to obtain all the necessary information, I will be fully responsible for all payments. I permit a copy of the authorization to be used in place of the original. If it is necessary to turn this account over to a collection agency/attorney, I agree to pay all reasonable costs of collections, attorney's fees and a one-time service charge of 25% of the balance due.

_____ _____

Signature of Patient or Legal Guardian Date