DEKALB HEALTH
MEDICAL GROUP

Workers Compensation Claim Information

MRN:_____

Patient Name: _____

Address: _____

Patient Phone: _____

Date of Birth: _____ SSN: _____

Accident Date: _____

Claim #: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Contact Person: _____

Name of Claims Administrator: _____

Address of Claims Administrator: _____

Claims Administrator Phone: _____

Contact Person: _____

Where should we send claims? (Choose one)
Employer _____ Claims Administrator _____

Please Note: In order to expedite the processing of your claim, please fill out all information completely and accurately. A report pertaining to this injury or illness must be filed with your employer. Payment for non-reported injury/illness or non-authorized treatment will be filed to the patient's medical insurance if there is one on file, otherwise the claim will become the responsibility of the patient

Signature: _____ Date: _____

Revised 02/02/2018