CENTER FOR WORK INJURIES
Another service from the Center for Orthopaedics & Sports Medicine

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Work Comp Billing Information Form

Patient Name:_____

Address:_____

_____

Phone #:_____

Date of Birth:_____SS#:_____

Date of Injury_____Claim#_____

Employer:_____

Address:_____

_____

Phone#:_____ Fax#:_____

WC Insurance Carrier:_____

Billing Address:_____

Phone#:_____ Fax#:_____

Nurse Case Manager: _____Phone#_____Fax#:_____

Patient understands if they do not have this information, it is their responsibility to obtain it or the bills will be sent to them.

_____ _____

Patients Signature **Date**

COSM
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