SCHNECK
URGENT CARE & OCCUPATIONAL MEDICINE

WORKER'S COMPENSATION VERIFICATION FORM

Schneck UC & OccMed 1124 Medical Place, Seymour, IN 47274
Phone: 812-523-5185 Fax: 812-523-3826

PATIENT INFORMATION: **EPISODE#:** _____ **DATE:**_____

Name _____**Birthdate** _____ **S.S. #:** _____

Address _____**Telephone** _____

INJURY REPORT:

Date of Injury: _____ **Time of Injury:** _____

Location Where Injury Occurred (department name, company vehicle, etc): _____

Description of Injury/Accident: _____

_____

Body Part Injured: _____

EMPLOYMENT INFORMATION (At time of injury):

Job Title*: _____ ***Please send/attach job description of injured team member.***

Employer: _____ **Contact:** _____

Telephone: _____ **Fax #:** _____

Address _____

WORKER'S COMPENSATION INSURANCE CO. INFORMATION:

Name: _____ **Claim #:** _____

Address: _____

Case Adjuster: _____ **Telephone:** _____

Email: _____ **Fax #:** _____

Nurse Case Manager: _____ **Telephone:** _____

Email: _____ **Fax #:** _____

Next Scheduled Appointment Date & Time: _____

☐ Send copy with the patient ☐ Fax/email form with progress notes to claim adjuster ☐ Fax/Email form to employer