WORKERS' COMPENSATION

Hand & Microsurgery Associates
John T. Burns, MD
P O BOX 2206, LEAGUE CITY, TX 77574-2206
Phone: 713-622-8382 Fax: 281-334-6853
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EMPLOYEE INFORMATION

Name: _____

Address: _____

_____

City/State/Zip: _____

Hm Phone: _____

Cell: _____

SSN: _____

DOB: _____

EMPLOYER INFORMATION

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Contact Name: _____

Phone: _____ **Ext**: _____

Fax: _____

Email: _____

WORKERS' COMPENSATION CARRIER INFO.

Case Number: _____

Name: _____

Claims Address: _____

_____

City/State/Zip: _____

Phone: _____

Adjustor: _____

Phone: _____ **Ext**: _____

Fax: _____

Email: _____

INJURY INFORMATION

1.) **Date of Injury**: _____

2.) Has employer made a first report of injury to their worker's compensation carrier? ☐ **Y** ☐ **N**

3.) Have you sought other medical treatment for this injury? ☐ **Y** ☐ **N**

4.) Have you had any x-rays, MRIs, or other testing for this injury? ☐ **Y** ☐ **N**

5.) Give a brief description of injury:

_____

_____

_____

_____

***** PRIOR TO SCHEDULING AN APPOINTMENT YOU MUST HAVE YOUR ADJUSTOR CALL OUR OFFICE. *****

I understand that if the Workers' Compensation carrier denies my claim I will be responsible for payment of all services associated with this injury. In the event my Workers' Compensation carrier denies my claim, my private health insurance carrier is (name/phone#) _____, my member ID# is _____, with a group# of _____.

Signature: _____ Date: _____