Workman's Compensation Claim Information*

**ALL INFORMATION MUST BE FILLED IN FOR PROPER FILING*

Patient Information

Patient Name: ____

Patient Address: ____

Patient Home Phone#: ____________________ **Patient Date of Birth:** ______________________

Patient Social Security#: __________________

Employer Information

Employer Name: ____

Employer Address: ____

Employer Phone#: ____

Workman's Compensation Information

WC Insurance Name: ____

WC Insurance Address: ____

WC Insurance Phone#: ____

WC Carrier Case#: ____

Place of Injury: ____

Date of Injury: ____

Time of Injury: ____

How did the Injury Occur? ____

Until a VALID workers compensation claim is established, you will be responsible for all charges. The information requested above is essential to establishing your claim. Your assistance is appreciated.

Signature: ______________________________

Brentwood Office	Huntington Office	Port Jefferson Office	Sayville Office	West Islip Office
(613) 231-4455	(613) 549-2020	(613) 331-1414	(613) 563-2206	(613) 661-3455