



411 Lantern Bend, Suite 240
 Houston, Texas 77090
 Tel (281) 444-6300 Fax (832)375-1247
 Email: info@MFASclinic.com

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| WORKERS' COMPENSATION INFORMATION |
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| NOTICE: | We MUST verify your injury and coverage BEFORE you are seen. Please notify the receptionist immediately! If we are unable to verify the information, you will be expected to pay for the services and submit your bill to your employer or insurance company. |
| Patient Name: | Date of Injury: |
| Briefly describe how you were injured: | |

Employer Information

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|---------------------------|----------|
| Employer: | |
| Address: | |
| Phone: | Fax: |
| Name of Supervisor: | Phone #: |
| Name of Person to Verify: | Phone #: |

Insurance Carrier Information

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|--------------------------|-----------------|
| Claim #: | |
| Insurance Carrier: | |
| Claims Address: | |
| Phone: | Fax: |
| Participating Provider: | |
| Dr. Moore _____ | Dr. Smith _____ |
| Adjustor Name: | |
| Adjustor Phone: | Fax: |
| Information Verified By: | Date/Time: |