URGENT CARE of Wilbraham
Bringing ER expertise to life's little emergencies
2040 Boston Road, Wilbraham MA 01095
Phone 413-599-3800 – Fax 413-279-1900

WORKER'S COMP PAYER INFORMATION FORM

Worker's Compensation Information

PATIENT INFORMATION [*Please print NEATLY & LEGIBLY*]		
FIRST	**LAST**	**DOB** / /

Did your employer send you here today? ☐ Yes ☐ No Do you have an injury report? ☐ Yes ☐ No

EMPLOYER NAME			Main Phone # ( ) -
Address:	City:	State:	Zip Code:

Your Manager / Supervisor's Name:	**Their Contact Number:** ( ) - Ext

DATE OF ACCIDENT/ INITIAL INJURY	**Location where injury occurred**
Your Occupation / Job Title	**Department / Division**

Insurance Carrier Name from Injury Report		Policy / Claim # (From Injury Report)
Address:	City:	State: Zip Code:

Claim Adjuster Name	**Their Contact Number:** ( ) - Ext

Notes or other pertinent information helpful to properly bill responsible party

X_____ _____ _____

Patient Signature Parent/Guardian Signature Relationship to Patient