Workers' Compensation and Auto Accident Claims

Name_____

Birthdate_____Date of Injury_____

Address_____

Cell_____Home_____Work_____

Medical doctor_____Phone_____

I grant permission to release any information necessary to process my bills, and I authorize direct payment to Dr. Brennan.

Patient signature_____Date_____

AUTO ACCIDENT CLAIM

Attorney_____Phone_____

Claim #_____

Auto Insurance Co_____

Adjuster's Name_____

Adjuster's Phone#_____

WORKERS' COMPENSATION CLAIM

Employer_____

Claim #_____MCO_____

Is an attorney involved?_____Name_____