WORKERS COMPENSATION SUPPLEMENTAL REGISTRATION FORM

PATIENT INFORMATION	
Name:	Account Number:

Is the employer listed on the original Patient Registration Form the employer responsible for your injuries? Y / N

If no, please list employer responsible for your injuries:

Employer		Occupation
Address:		Phone ( )
City:	State:	Zip Code:

Have you been assigned a Case Manager who oversees your care? Y / N

Name	Phone ( )

Are you represented by an attorney in your claims? Y / N

Attorney:		
Law Firm:		
Address:		
City:	State:	Zip Code:
Phone ( ) -	Facsimile ( ) -	

Do you currently have an Application / Claim Dispute on file with the Illinois Workers Compensation Commission?

Y / N

If this should change, please notify our office immediately.

X	
Patient / Guardian Signature	Date

In the event your medical claims are to be submitted to a group health plan for injuries sustained in a work related injury you may be responsible for deductibles, co-payments or coinsurance, depending upon the plan design.

Internal Use Only

Utilization Review Report Required: Y / N Due Date: ______________________

Date Submitted: ______________________

AD-F006 Rev: 05/12/2021