Worker's Compensation Insurance

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Insurance Carrier:_____

Claim Number #:_____**Date of Injury:**_____

Adjuster Name:_____ **Phone Number:**_____

Claims Billing Address:_____

_____ _____ _____

City *State* *Zip*

Occupation at time of injury:_____

Employer at time of injury:_____

Employer's Address:_____

_____ _____ _____

City *State* *Zip*

What happened?: _____

Where did it happen?:_____

Is an attorney involved?: Yes No

(If so, please list the name and phone number of attorney currently working your case)

Name:_____ **Phone #:**_____

Is your claim: Closed Open Litigation Palliative Care Only

(*please circle)*