



WORKERS COMP INFORMATION FORM

*****THIS FORM MUST BE COMPLETED IF YOU ARE BEING SEEN FOR A
WORKERS COMPENSATION INJURY*****

ORTHOPEDIC ASSOCIATES OF SW OHIO, INC.

Patient Name: _____

Social Security # _____ - _____ - _____ Day Phone (_____) _____ - _____ Ext: _____

Where were you employed when injured? _____

Employer address: _____

City, State, Zip: _____

Employer phone # (_____) _____ - _____ Contact/HR Person: _____

Date of injury: (MUST HAVE TO FILE BWC CLAIM): _____

Have you been able to work since the first date of injury? Yes _____ or No _____

If no, please provide the date you last worked? _____

Have you completed a First Report of Injury (FROI)? Yes _____ or No _____

If you have not filed this form, please ask to speak with our BWC personnel

Managed Care Organization (MCO) or Self-Insured Company:

BWC Claim or Social Security number: _____

Allowed condition(s) on claim: _____

Body Part injured - Indicate Right or Left: _____

Please give a description of how your injury occurred (do not use "at work" or similar statements):

Check one: My on-the-job accident was the one and only cause of my present condition

My on-the-job accident aggravated a condition that already existed prior to my accident

Private Insurance Information: Company: _____ ID # _____

Patient Signature

Date

A copy of your private insurance card is needed for your file. It will be used only if your Workers Compensation claim is denied. If your private insurance carrier requires a referral, you should inform your Primary Care Physician of this fact and ask that your chart be noted. By following these steps, if your claim is denied, the referral may be obtained.