***Chelmsford Primary Care, LLC***
***2 Meeting House Road, Chelmsford, MA 01824***
***Phone: 978-256-5522  Fax: 978-256-5399***

# Worker's Comp Information Request Form

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| Patient Name: |
| Date of Birth: |
| Date of Accident: |
| Type of injury: |
| Name of Insurance Company: |
| Worker's Comp Claim Number: |
| Address to Submit Claims w/ Medical Records: |
| Address City, ST, ZIP: |
| Claim Adjuster Name (If Known): |
| Adjuster Phone Number (If Known): |

_____ _____
Patient's Signature Date

By signing this form, you authorize Chelmsford Primary Care to release office & billing notes related to your work injury to be processed by the above stated employer's workers comp company.

- This form needs to be completed in its entirety and is required to file a WC Claim.
  Forms can be faxed back to 978-256-5399 Attn: Billing
    - Information needs to be provided within 7 days.
    - If the requested information remains incomplete, you will be liable for the visit in its entirety.
    - Full Worker's Comp Insurance Addresses are required including City and State.

- As a courtesy to our patients, we will submit a claim to the workers comp insurance carrier ONCE.
    - A copy of the visit and claim form will be sent to the patient.
    - After 30 days, if the visit remains unpaid, it will default to patient responsibility.
    - The patient will have to then speak directly with their company's HR to finalize the claim.