WORKER'S COMPENSATION INFORMATION

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR WHERE TO SEND OUR BILLINGS:

EMPLOYEE:_____

ADDRESS:_____

DATE AND TIME INJURED:_____

EMPLOYER:_____

ADDRESS:_____

TELEPHONE NUMBER:_____

INSURANCE CARRIER:_____

CLAIM NUMBER:_____

ADDRESS:_____

TELEPHONE NUMBER:_____

FILLED OUT BY:_____ DATE:_____

PLEASE FAX TO: 1-920-465-4464