COMPREHENSIVE PROSTHETICS & ORTHOTICS

WORKER COMPENSATION REGISTRATION

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)

RESPONSIBLE EMPLOYER *(If not the same employer on PATIENT REGISTRATION FORM)* EMPLOYER			PHONE NUMBER
			( ) -
CONTACT PERSON	CONTACT PERSON TITLE		
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

CASE MANAGER INFORMATION *(if one has been assigned to your case)* NAME	PHONE NUMBER
	( ) -

ATTORNEY INFORMATION *(if currently represented by an attorney for these claims)* NAME			PHONE NUMBER
			( ) -
LAW FIRM			FACSIMILE NUMBER
			( ) -
ADDRESS	CITY	STATE	ZIP CODE

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

Y / N

In the event this changes, please notify our office immediately.

Signature

Date

Representative's Signature

Date

Representative's Printed Name

Relationship to Patient

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.