CPO
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.