



Setting the Standard in Eye Care

WORKMAN'S COMPENSATION CLAIM INFORMATION

Patient name: _____

Patient Address: _____

Patient Phone #: _____ Patient Date of Birth: _____

Patient Social Security #: _____

EMPLOYER INFORMATION

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

WORKMAN'S COMPENSATION INFORMATION

WC Insurance Name: _____

WC Insurance Address: _____

WC Insurance Phone #: _____

WC Carrier Case #: _____

Place of Injury: _____

Date of Injury: _____

Time of Injury: _____

How did the Injury Occur? _____

**Until a Valid workers compensation claim is established, you will be responsible for all charges
The information requested above is essential to establishing your claim. Your assistance is appreciated.**

Patient's Signature: _____