WORKERS' COMPENSATION PHONE VERIFICATION REQUEST

(TO EMPLOYER)

NOTE: THIS FORM MUST BE COMPLETED IMMEDIATELY, prior to filling out and sending in the "Pink First Report of Work Injury." PLEASE call patient's employer for all work related injuries.

Patient Name _____ Date of Injury _____

Date of Call _____ Name of CA or Doctor who called _____

Time of call _____ Employer Telephone No. _____

Insurance Company _____ Phone No. _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Name of Person you Spoke With _____

SUGGESTED TELEPHONE DIALOGUE: (When calling the employer, ask for personnel)

"Mrs. Brown, this is _____ at Dr. _____ office. We have a patient who has reported to our office for examination and treatment due to an injury on the job and states that you are his/her employer. I need verification of this and the name of your Insurance Carrier."

Pause and wait for the answer.

"Thank you very much Mrs. Brown. This completes our records for now."

(PLEASE FILE THIS FORM IN THE PATIENT'S FILE AS A PERMANENT RECORD)

#1073
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