

**Mid-South Surgeons, PLLC**  
**WORKER COMPENSATION INFORMATION**

Date: \_\_\_\_\_

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Soc Sec # \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Occupation: \_\_\_\_\_

**EMPLOYER**

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City State Zip

Employer Telephone: \_\_\_\_\_ Injury Verified by (For Office Use) \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**WORKER COMPENSATION CARRIER (FOR OFFICE USE)**

Worker Compensation Carrier: \_\_\_\_\_ Carrier Phone: ( ) \_\_\_\_\_

Carrier Address: \_\_\_\_\_  
Street City State Zip

Coverage Verified by: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_ Claim #: \_\_\_\_\_

Case Manager Name: \_\_\_\_\_ Case Manager Number: \_\_\_\_\_

Utilization Review Contact: \_\_\_\_\_ UR Number: \_\_\_\_\_

**INJURY INFORMATION**

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM Accident Reported to Employer?: \_\_\_\_\_

Give full description of how accident happened: \_\_\_\_\_  
\_\_\_\_\_

Other Physicians seen for this condition: \_\_\_\_\_

**AUTHORIZATION**

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

Date: \_\_\_\_\_ Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_