Southern Illinois Sports Medicine

Auto Accident/Worker's Compensation/Third Party Liability

Today's Date ________________

Patient ____

Birthdate ___________________

Is your visit today the result of a worker's compensation injury, automobile accident or other third party liability? If so, please describe in detail when, where and how injury occurred.

Please provide the following billing information:

Date of injury ________________

Claim number ________________

Insurance Carrier ______________________________________
(Insurance Co. responsible for bill)

Contact Person ______________________________________

Contact Person Phone Number ____________________________

Address ____

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Have you already reported this claim to your Employer/Insurance Company?