

## **WORKER'S COMPENSATION FORM**

**\*\*\*INFORMATION MUST BE RECEIVED WITHIN 24 HOURS\*\*\***

*Please be as complete as possible so that we can file with your insurance carrier*

Patient Name: John Smith Date of Service: 08/22/2020

DOB: 05/22/1983 Phone Number: 512-123-456

Employer Name: City of Round Rock, Texas

Address: 231 E. Main Suite 100

Phone Number: 512-801-5357

Worker's Compensation Insurance: Texas Municipal League

Address: P.O. Box 149194

Austin, TX 78714

Phone Number: 512-491-2300 Adjuster: Ruth Brown

Policy Number: 3127

Claim Number: Last 4 of SSN. Claim has not been set up yet

**Check one:**

TWCC Subscriber

Non-Subscriber Self-Insured

**PLEASE FAX WITHIN 24 HOURS TO (512)341-5539**

**ATTN: WORKER'S COMPENSATION**