**Paul H. Deutsch M.D., R.Ph., LLC**
86 New London Turnpike Norwich, CT 06360
Phone: 860 889-6967 Fax: 860 885-1033

# WORKERS COMPENSATION FORM

## EMPLOYEE

Name ______________________________________________

D.O.B. ______________________________________________

Address ____________________________________________

City/Town __________________________________________

Zip Code______________ Tel. #________________________

## PERSONAL INSURANCE INFORMATION

Primary Insurance ____________________________________

Subscriber Name _____________________________________

D.O.B. ______________________________________________

Relationship to Subscriber _____________________________

ID# ________________________________________________

Secondary Insurance __________________________________

Subscriber Name _____________________________________

D.O.B. ______________________________________________

Relationship to Subscriber _____________________________

ID# ________________________________________________

## EMPLOYER

Name _______________________Tel. #________________

Address _____________________________________________

City/Town _________________State________Zip__________

## INJURY

Date of Injury_______________________________________

City/Town of Injury___________________________________

State ______________ Zip Code________________________

Body Part(s) ________________________________________

Cause of Injury______________________________________

____________________________________________________

Reported to Employer on _____________________________

## INSURER

Workers Compensation Insurance Carrier

____________________________________________________

Address ____________________________________________

City/Town ___________________State__________________

Zip Code ____________________________________________

Claim Number _______________________________________

Claim Representative _________________________________

Tel. #_______________________________________________

**I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.**

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**PATIENT SIGNATURE**

**IF THE WORKERS COMPENSATION CARRIER DENIES THIS CLAIM, I AM RESPONSIBLE FOR PAYMENT OF THESE SERVICES AND FOR ALL COSTS. THEREFORE, I AUTHORIZE THE PAYMENT FOR SERVICES RENDERED BY PAUL H DEUTSCH, M.D. RPH. DIRECTLY TO HIM BY MY INSURANCE FOR COSTS DENIED BY THIS WORKERS COMPENSATION CLAIM.**

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**PATIENT SIGNATURE**