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. ____

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

____

Claim Address

____

City/Town ___________________State__________________

Zip Code ____

Claim Number _______________________________________

Claim Representative _________________________________

Tel. #____

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

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PATIENT SIGNATURE **DATE**

Revised 11/2024