Dr. Demarque In-Network WC Networks:

Coventry Insurance

(subcontracts):

-First Health

-CSS

-Travelers

-Bunch

-Liberty

-Chartis

-The Hartford

-Genex

-Texas Star/Texas Mutual

-Zenith

-Zurich Services

-Sedgwick

WORKERS' COMPENSATION INTAKE FORM

I. PATIENT INFORMATION

Name: _____

Address: _____

City/State/Zip: _____

Home Number: (_____) _____ Cell number: (_____) _____

Social Security number: _____--_____--_____ DOB: _____/_____/_____

II. EMPLOYER INFORMATION

Employer Name: _____

Address: _____

City/State/Zip: _____

Work Number: (_____) _____ Supervisor Name: _____

III. WORKERS' COMPENSATION INSURANCE INFORMATION

Insurance Carrier: _____ Network Name: _____

Address: _____

City/State/Zip: _____

Phone Number: (_____) _____ Fax number: (_____) _____

Adjuster Name: _____

Claim Number: _____ Date of Injury: _____/_____/_____

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

IV. PREAUTHORIZATION REQUEST INFORMATION

Date Requested: _____/_____/_____ Requested By: _____

Provider Name: _____ NPI: _____

Facility Name: _____

Address: _____

City/State/Zip: _____

Phone Number: (_____) _____ Fax number: (_____) _____

Dates of Service Requested: _____

ICD-9 Codes: _____ CPT Codes: _____

Treatment Plan: _____

Date Approved: _____/_____/_____ Number of Visits Approved: _____

Office Manager Signature:_____ Date: _____

WORKERS' COMPENSATION INFORMATION FORM

PATIENT NAME: _____

1. What was the date of the injury? _____
2. What time did the injury occur? _____
3. What is the name of your employer? _____
4. What is the street address of your employer? _____
5. What is the city, state, and zip of your employer? _____
6. What is the name of your attorney? _____
7. What is the street address of your attorney? _____
8. What is the city, state, and zip of your attorney? _____
9. Please describe your incident in a few sentences:

   _____

   _____

   _____

   _____

10. Did you report the incident to your supervisor? Yes or No
11. What is your supervisor's name? _____
12. Did your employer send you to a doctor or did you go on your own? _____
13. What did the doctor diagnose you with? _____
14. Are there any other problems that affect your employment? If so, please describe:

    _____

    _____

15. Does your job cause you to favor one side of your body? If so, which side: _____
16. Before the injury, were you capable of performing equal work with others your age? _____
17. Have you injured this area before? Yes or No
18. If yes, please explain: _____

Patient/ Guardian Signature: _____ Date: _____