Worker's Compensation Verification Form

Patient Name: **DOB:**

Body Parts included in Case:

Date of Injury:

Carrier Case #:

WCB #:

WC Carrier Name:

WC Carrier Address:

Phone Number:

Fax Number:

Adjuster Name:

Adjuster Phone #:

Variance Fax #:

Employer Name:

Employer Address:

Employer Phone #:

Have you been scheduled for an Independent Medical Exam? Yes / No