Adair County Health System
we surround you with care

Adair County Medical Clinics

Worker's Compensation Information

The following is information required for submitting work-related injury to work-related illness charges to your worker's compensation insurance company.

If you do not or are unable to give complete information, the charges will be your responsibility until such time as information is provided to us.

Patient Information		
Patient Name:	DOB:	Date:
Sex: ☐ Male ☐ Female		

Date of Injury:		Do you have any other Worker's Compensation injuries? ☐ Yes ☐ No
Type of Work Injury or Work Illness:		
Home Phone:	Cell Phone:	Work Phone:

Employer Information We need the full mailing address of your employer.		
Employer:		Phone:
Address:		
City:	State:	ZIP
Claim Number (if known) or Supervisor Name:		

Please provide the information below of your **Employer's Worker's Compensation Insurance Company**		
Insurance Company Name:		Phone:
Address:		
City:	State:	ZIP
Claim Number (if known):		

Authorization for Release of Medical Information	
I authorize the release of medical information and/or copies of my health records to the above named insurance company for the purpose of determining worker's compensation benefits related to the injury / illness that occurred on:	
Date of Injury:	
To Body location or injury- be specific:	
Signature:	**Date:**
Witness:	**Date:**
(If patient is unable to sign, but uses X or mark)	