

NAME (PLEASE PRINT) _____

OPC ACCOUNT NUMBER _____

O·P·C
ORTHOPAEDIC
PHYSICIANS OF
COLORADO, PC

WORKMAN'S COMPENSATION FORM

PLEASE READ CAREFULLY

**YOU MUST NOTIFY YOUR EMPLOYER OF INJURY OR ILLNESS FOR THIS CLAIM TO BE PROCESSED.
FAILURE TO DO SO MAKES YOU PERSONALLY RESPONSIBLE TO PAY THIS ACCOUNT.**

Not all workman's compensation claims are handled by the state. In many instances, employers have their own private insurance which covers your injury, and in this case, the billing process is handled differently. All information below must be filled in accurately. If you are not absolutely sure about the way to answer a question, please ask someone at the desk to allow you to use the phone in order to obtain the correct information.

Date of Injury: _____

Employer Information Name: _____

Address: _____

City and State: _____

Telephone: _____

Supervisor/Contact: _____

Have you filed an accident report with your employer? _____

Insurance Carrier: _____

Address: _____

City and State: _____

Telephone: _____

Claim #: _____

Adjuster's Name: _____

If you have missed work due to this injury, list dates _____

I have read and filled in, to the best of my knowledge, all of the above information for filing my workman's compensation claim. I understand that my failure to report this accident/illness to my employer makes me personally responsible for this account.

SIGNED _____ DATE _____