Milford Regional Physician Group
The Benchmark for Quality Care

Worker's Compensation Form

Please provide the following information so that we are able to submit a claim, on your behalf, to your Employer's Worker Compensation Insurance Company:

Patient Name: _____ **Date of Birth:** _____

Date of Injury: _____ **Time of Injury:** _____

Employer: _____

Employer Address: _____ **Employer Phone:** _____

Employer Fax: _____

City: _____ **State:** _____ **Zip:** _____

Employer Contact Name/Title: _____

Claim Number: _____

Worker's Compensation Insurance: _____

Insurance Address: _____ **Insurance Phone:** _____

Insurance Fax: _____

City: _____ **State:** _____ **Zip:** _____

Insurance Contact Name: _____

This information must be received in order for the Worker's Compensation Insurance Company to pay for the services rendered by our physician.

If you do not have the above information, contact your employer.

If unable to complete the required information prior to your visit, please complete the form as soon as possible and return to:

Milford Regional Physician Group, Inc.
9 Industrial Road, Suite 5
Milford, MA 01757
Fax: 508-473-1210

Questions, please call Milford Regional Physician Group Billing @ 508-473-1480 ext 116