# 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:

Tri-County Medical Associates
9 Industrial Road, Suite 5
Milford, MA 01757
Fax: 508-473-1210

Questions, please call Tri-County Billing @ 508-473-1480 ext 116