MISSOULA Bone & Joint & Surgery Center

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Workers' Compensation Insurance Information

It is your responsibility to provide us with your Workers' Compensation insurance information. Please complete and return this form as soon as possible. **You will be financially responsible for the medical services that you receive until we receive this information.** Your employer should be able to provide this information to you. Please keep in mind that we do not bill OWCP or some out of state work comp. Thank you!

Patient's Name: _____ Date of Birth: _____

Work Comp Insurance Carrier:_____

Address for Claims: _____
(unless the Carrier is MT State Fund or Liberty Northwest)

Claim Number: _____ Date of Injury:_____

Injured Body Part:_____ Accident happened in which state?_____

Name of Adjuster:_____ Adjuster Phone:_____

Employer at time of injury: _____

Employer Address:_____