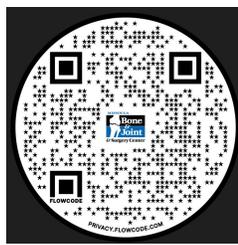




2360 Mullan Road Ste. C  
Missoula, MT 59808  
Ph. (406) 721-4436  
Fax (406) 721-6053

## 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: \_\_\_\_\_