# WORK-RELATED INJURY INFORMATION

Patient Name: _____

Date of Accident: _____ Claim Number: _____

☐ Washington State Fund L&I ☐ Self-Insured L&I ☐ Unknown

Employer:_____

Employer/HR Contact:_____

Phone:_____ Fax: _____

Attending Physician: _____ Clinic or Hospital: _____

Physician Phone: _____

Referral?: ___Yes ___No ___Unknown ☐Pt will obtain ☐Staff will request ☐Will fill out transfer of AP Card

Accepted Diagnosis_____

Claim Status (open, pending, closed):_____ Effective_____

Auto Accident? _____ Yes _____ No

Claims Adjuster: _____

Phone:_____ Fax: _____

Verified by: _____ Date: _____

Self-Insured L&I Only:

Insurance Company Name:_____

Billing Address: _____

_____

Claims Adjuster: _____

Phone:_____ Fax: _____

Employer:_____

Employer/HR Contact:_____

Phone:_____ Fax: _____

Legal Representation?

_____ Yes _____ No If yes, with whom?

Name: _____ Phone:_____

Date_____