WORKERS COMP INJURY QUESTIONNAIRE

Thank you for choosing Rice Memorial Hospital for your health care needs.

So that we can process your claim correctly, please fill in the injury details below and then bring this form to your employer to complete and return to our Business Office.

Please complete and return this form within 48 hours

PATIENT _____ ACCOUNT NO: _____

Injury Date: _____ Time: _____

Accident Location: _____

Accident Details (What happened?) _____

_____

Employer: _____

Contact Person: _____ Telephone: _____

Employer's Address: _____ State: ____ Zip: _____

Work Comp Insurance Name: _____ Phone: _____

Insurance Address: _____ City: _____

File Case Number: _____ State: _____ Zip: _____

Please FAX this questionnaire to our Business Office at 1-320-231-4879.

wcquest 5/98
rev. 11/00

RICE MEMORIAL HOSPITAL
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