

Luedtke-Storm-Mackey Chiropractic Clinic

Patient
Work Injury
Report

Our office will use this report to contact your employer to verify that a work injury claim has been filed. *Until you file a claim with your employer, worker's compensation will not process any medical bills for payment.* If you have questions or problems with your work injury claim, you can contact the Wisconsin Department of Workforce Development.

Worker's Compensation Division Bureau of Insurance Programs P.O. Box 7901 Madison, WI 53707-7901	Voice: Fax: Email:	608/266-3046 or 608/266-1340 608/266-6827 DWDWCINS@dwd.state.wi.us
---	--------------------------	--

Name		SSN	Date of Injury
Daytime phone	Best time to call	Health Insurance Carrier	
Describe how you were injured			

Have you retained an attorney? <input type="checkbox"/> No <input type="checkbox"/> Yes	Attorney's Name	Phone Number
Attorney's Street Address	City	State Zip

Employer's Name			
Supervisor's Name		Supervisor's Phone Number	
Employer's Street Address		City	State Zip
Employer's Insurance Carrier		Insurance Carrier Phone #	
Internal Use Only			

I authorize submission of all bills to my employer or work comp carrier. In compliance with work comp guidelines, I understand all records pertaining to care will be submitted as well. I further understand that until worker's compensation accepts liability, I am responsible for all charges.

Patient Signature _____ Date _____

Please provide as much information as possible when completing this injury report.

We will gladly make a copy of this form upon your request.