ESSEX ORTHOPAEDICS &
OPTIMA SPORTS MEDICINE

16 Pelham Road, Suite 1
Salem, NH 03079
Ph: 603-898-2244
Fx: 603-898-2227

Workman's Compensation Information

Date: _____ **Patient Account #:** _____

Dear Patient:
In order to bill you medical charges as a workman's compensation claim, this form must be filled out in its entirety and returned to Essex Orthopaedics within 14 days from the above date. If this form is not returned within 14 days, or is returned with incomplete or inaccurate information, we will assume the claim is not related to an industrial accident or cause and we will bill you for payment.

Patient Name: _____

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

Industrial Accident Report Filed? **YES** _____ **NO** _____

Date of Accident: _____ **Accident Claim #:** _____

State Where Injury Occurred: _____

Employer Human Resource Representative: _____

Employer's Workman's Compensation Insurance Company

Name: _____

Address: _____

_____

Name of Claim Representative: _____

Claim Rep. Phone #: _____ **Fax #:** _____

Attorney's Name, Address and Phone Number (if applicable):

_____

_____