Carolina Infectious Disease PA

1774 Metromedical Drive Fayetteville, NC 28304
Office: (910) 568-3903 Fax: (910) 568-3908

Worker's Comp Verification Form

Today's Date: _____

Patient Information

Last Name: _____ First Name: _____ MI: ____

Mailing address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth (mm/dd/yyyy): _____ Social Security #: _____

Employer Information

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Employer Phone: _____

Worker's Compensation Insurance Carrier Information

Worker's Comp Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Case Manager Phone: _____

Claim #: _____ Date of Injury: _____

- ***All of this information must be filled out prior to your appointment.***
- ***If your claim(s) is (are) denied by the worker's comp insurance carrier listed above, then the balance becomes the responsibility of the patient.***

_____ _____

Patient/Guardian Signature Date