FOOT PERFORMANCE CENTER

WORKERS COMPENSATION FORM

Name: _____ **Date:** _____

____ Male ____Female ____Single ____Married ____Other

Home Phone: _____ **Bus. Phone:** _____ **Cell:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

D.O.B.: _____ **S.S. #** _____
(required for workers comp. claim)

Employer: _____

Date of Injury: _____

WCB Case #: _____

Carrier Case #: _____

Insurance Carrier: _____

Address: _____

Case Worker: _____
It is necessary that we have the name and phone number of your current caseworker.

Case Worker Phone #: _____

Fax #: _____

We will contact your caseworker for verification of benefits before dispensing any items. Verification of benefits is not a guarantee of coverage. Actual coverage is determined at the time the claim is received by Workers Compensation. If payment is denied I understand that I am responsible for payment of my invoice.

I authorize the release of any medical or any other information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment.

Signature: _____