Dickson Orthotics & Prosthetics

Worker's Compensation/ Automobile

Worker's Compensation

☐ **Please check here** if your injury is a worker's compensation injury and complete the section below.

Employer Name (at time of injury) _____

City _____State _____ Date of Injury _____/_____/_____

Insurance Carrier Name_____ Claim #_____

Claim Adjuster_____ Phone _____

Auto Accident/ Third Party Liability

☐ **Please check here** if your injury was due to an auto accident.

☐ **Please check here** if your injury was due to third party liability (someone else is liable for your injury)

☐ **Please check here** if you have an attorney. Attorney Name _____ Phone _____

Office Use Only

HCPS Code_____ Diagnosis _____
Authorization Number _____ Amount_____
Claim Adjuster _____ Phone_____
Type of Claim (Circle One) Standard CMS-1500 / Invoice
Fax Number _____ Date Faxed _____
Address _____
City _____ State _____ Zip _____

Dickson O&P Representative _____ Date _____