Orthoclinic
Orthopaedic Clinic Sydney

AFFIX PATIENT LABEL HERE

WORKERS COMPENSATON / THIRD PARTY

Claim Number: _____

Date of Injury: _____

Insurance Company: _____

Insurance Company Address: _____

_____

Insurance Case Manager Name: _____

Case Manager Telephone: _____

Case Manager Fax: _____

Employers Name: _____

Employers Address: _____

_____

Employers Contact Person: _____

Employers Telephone: _____

I _____ have provided the information to the best of my knowledge and understand that I will be personally responsible for the cost of all medical fees should the cost not be met by my insurer.

Signed: _____ Date: _____