Mercyhealth
A passion for making lives better.

Worker's Compensation Accident/Injury Insurance Information Form

Section A: Patient Information (To be completed by patient)

Name:_____ Date of Injury:_____
Phone Number:_____ Type of Injury/Body Part Injured (Be Specific):_____
Date of Birth:_____ _____
State Accident Occurred In: ☐ WI ☐ IL
☐ Other (Please Specify What State):_____

Employment Information at Time of Injury

Employer's Name:_____ Phone:_____
Address:_____City:_____
State:_____Zip:_____

Section B: Worker's Compensation Insurance to be billed for this accident (To be completed and signed by Employer)

Insurance Company Name:_____ Claim Number:_____
Address:_____City:_____ Claim Adjuster's Name:_____
State:_____Zip:_____ Claim Adjuster's Phone:_____
Phone:_____ Claim Adjuster's Fax:_____

We as the employer hereby acknowledge the above-mentioned patient is seeking medical services with Mercy Health for a work-related injury/illness.

Printed name of authorized employer representative:_____Phone:_____

Signature of authorized employer representative:_____Date:_____Time:_____

Completed forms should be emailed to WCRegistrationSpec@mhemail.org or faxed to 608-314-2526 prior to your appointment. If there are any questions in regards to this form please contact Mercy Work Comp Registration Department at 608-757-3130.