California Injured Worker Intake Form

daisyBill

Injured Worker Demographics

Last Name: *	First Name: *	Middle Init:
Date of Birth: *	SSN: *	Gender: * F ☐ M ☐
Address: *		
City: *	State: *	Zip: *
Telephone:		

Claims Administrator Information

Claims Administrator Name: *		
Address:		
Adjustor Name:	Telephone:	Fax:
Email:		

Injury Claim Information

Claim Number: *	Claim Status: ☐ Accepted ☐ Disputed ☐ Denied ☐ Other
Injury Start Date: *	Injury Description:

Request for Authorization Information

RFA Fax Number:

Employer MPN Information

Employer Name: *	
MPN Name:	MPN Weblink:

Primary Treating Physician Information

Last Name:	First Name:
Practice Name:	Specialty:
Telephone:	PTP Effective Date:

Injured Worker Referred By

Name:	Company:	Telephone:
Role: ☐ Adjustor ☐ Employer ☐ Applicant Atty ☐ Defense Atty ☐ Other		

Additional Notes

Completed By: _____ Date: _____

* Indicates information required for compliant billing