

## WORKER'S COMPENSATION VERIFICATION FORM

Moore Orthopedics & Sports Medicine, P.A. requires written verification of your employee's worker's compensation. Until this information is received, the employee is responsible for medical bills. Please fax to 252-808-3120.

1. Employee's name: \_\_\_\_\_

2. Employee's date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Date of injury: \_\_\_\_\_

4. How injury occurred:

\_\_\_\_\_

5. Employer name and address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone number: \_\_\_\_\_

6. Supervisor name (print): \_\_\_\_\_ Title: \_\_\_\_\_

7. Supervisor signature: \_\_\_\_\_

8. Worker's comp. insurance name and address:

\_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_