Bullis Orthopedics And Sports Medicine

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Questions: 508-558-4148

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David W. Bullis, M.D.
Brad E. Green, D.O.
Alan R. Zephrani, M.S., P.A.-C.

VERIFICATION OF WORKERS COMPENSATION INJURY

EMPLOYEE:

Name _____

D.O.B. _____ Phone _____

Address _____

_____

EMPLOYER:

Name _____

Address _____

_____

Phone _____

WORKER'S COMPENSATION INSURANCE:

Name _____

Address _____

_____ Adjuster _____

Phone _____ Fax _____

Claim No. _____ Date of Surgery _____

UTILIZATION REVIEW COMPANY:

Name _____

Phone _____ Fax _____

Reason for Visit: _____

_____

_____

_____

_____

_____

_____

IT IS THE RESPONSIBILITY OF THE PATIENT TO ENSURE THAT THIS FORM IS PROPERLY COMPLETED AND RETURNED PRIOR TO TREATMENT.