Rice Memorial Hospital

WORKERS COMP INJURY QUESTIONNAIRE

Thank you for choosing Rice Memorial Hospital for your health care needs.

So that we can process your claim correctly, please fill in the injury details below and then bring this form to your employer to complete and return to our Business Office.

Please complete and return this form within 48 hours

PATIENT ________________________ ACCOUNT NO: ____________________

Injury Date: ______________________ Time: ______________________

Accident Location: ____

Accident Details (What happened?) ______________________________________

____

Employer: ____

Contact Person: __________________________ Telephone: ______________

Employer's Address: __________________________ State: ____ Zip: __________

Work Comp Insurance Name: ________________________ Phone: ___________

Insurance Address: ____________________________ City: __________________

File Case Number: ________________________ State: _______ Zip: _________

Please FAX this questionnaire to our Business Office at 1-320-231-4879.

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RICE MEMORIAL HOSPITAL
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8310-0020-29