WORKER'S COMP ACCIDENT INSURANCE QUESTIONARE

Must be completely filled out in order to process claims

Patient's Name: ______________________________

Address: ______________________________

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Phone #: ______________________________

Date of accident: ______________ Claim #: ______________

Description of injury ______________________________

Insurance Carrier ______________________________

Claim Submission Address ______________________________

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Employer: ______________ Phone Number: ______________

I authorize the release of any medical information necessary to process this claim.
I permit a copy of this authorization to be used in place of the original.

I hereby authorize Macomb Physicians Group, PLLC. to submit claims on my behalf for services rendered.

I authorize that payments from my insurance company be made directly to Macomb Physicians Group, PLLC.

I certify that the information I have provided is correct.

Signature: ______________ Date: ______________