833-509-OCLI
(833-509-6254)

OCLI VISION

ocli.net

WORKERS' COMPENSATION PATIENT INFORMATION

Patient Name:
Patient Address:
Patient Phone #:
Patient Date of Birth:

EMPLOYER INFORMATION

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

WORKERS' COMPENSATION INSURANCE INFORMATION

WC Insurance Name: _____

WC Insurance Address: _____

WC Insurance Phone #: _____

WC Carrier Case #: _____

Date of Injury: _____

How did the Injury Occur: _____

Until a *VALID WORKERS' COMPENSATION* claim is established, you will be responsible for all charges. The information requested is essential to establishing your claim. Your assistance is appreciated.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERICAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERICAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____	_____	_____
Signature of Patient/Legal Guardian	**Print Name**	**Date**
_____	_____	_____
Healthcare Proxy (If applicable)	**Print Name**	**Date**