DuPage Medical Group

WE CARE FOR YOU

Workers' Compensation Form

If your illness or injury is related to your work, your company carries insurance to pay your medical bills. Please complete this form so that your claim is filed with your company properly. If you agree to a settlement under the workers compensation act, be sure that all your medical bills have been included in the settlement. **If your claims are denied under the worker's compensation act, you will become fully responsible for payment.** You should then contact our Customer Service Department at 630-942-7998 to make payment arrangements.

PATIENT INFORMATION

PATIENT: _____
Last Name First Name MI

DATE OF BIRTH: _____ SOCIAL SECURITY #:_____-_____-_____

EMPLOYMENT INFORMATION

EMPLOYER AT TIME OF INJURY: _____ PHONE: (_____)_____

EMPLOYER'S ADDRESS: _____
Street Address City State Zip Code

REPORT OF INJURY COMPLETED? ☐YES ☐NO REPORTED TO :_____
Name / Title

PHONE: (_____)_____ FAX: (_____)_____

INJURY DETAILS

DATE OF INJURY: _____ TYPE OF INJURY (BODY PART(S) INVOLVED):_____

HOW DID INJURY HAPPEN? (FALLING, TRIPPING, ETC.): _____

ANY PRIOR TREATMENT BY OTHER PROVIDERS? ☐ YES ☐ NO

IF YES, WHAT TYPE OF PROVIDER? ☐EMERGENCY ROOM ☐OCCUPATIONAL HEALTH ☐COMPANY MD ☐PRIMARY CARE PROVIDER ☐OTHER

PROVIDER OR HOSPITAL NAME: _____ PHONE #: (_____)_____

CLAIM INFORMATION

If the following information is unknown at the time of the appointment, please contact your employer for the required information and contact our Customer Service Department within 5 business days. Failure to provide this information may result in any balance from your visit becoming your responsibility.

RESPONSIBLE INSURANCE COMPANY: _____

CLAIMS ADDRESS: _____
Street Address City State Zip Code

CLAIM NUMBER: _____ CLAIM ADJUSTER:_____

PHONE #: (_____)-_____ __ FAX# : (_____)-_____ NURSE CASE MANAGER ASSIGNED? ☐YES ☐NO

IF YES, NCM NAME: _____ PHONE: (_____)_____ FAX: (_____)_____

ATTORNEY ON FILE? ☐ YES ☐ NO ATTORNEY NAME:_____ ATTORNEY PHONE #:(_____)_____

ATTORNEY FAX #:(_____)_____ ILLINOIS WORKERS' COMPENSATION CLAIM # (if claim filed) _____

I hereby authorize DuPage Medical Group to release to my employer, workers' compensation representative, or their designees, any information which may be requested concerning my condition or treatment.

Signature: _____ Date: _____

DMG Staff Instructions: Email completed form to Registration (rq-regqueue) and send the original form to the Workers Compensation Team at Highland Oaks via interoffice mail.