BEAR VALLEY URGENT CARE

12186 HESPERIA RD VICTORVILLE,CA 92395

PH: 760-381-8848 FAX: 760-381-8810

WORKERS COMPENSATION INFORMATION SHEET AND EMPLOYER AUTHORIZATION

Employee Information

Patient Name:________________________________ DOB:___________________________

Patient Address:____

Phone #:_________________________ Driver's License/ SSN #:____________________________

Job Title:____

First Office Visit:__________________ Date of Injury:______________________________

Reason for visit (brief description/specify body part injured):______________________________

Employer Information:

Employers' Name:____

Employers' Address:____

Employers' Phone #:__________________________ Contact Name:___________________

Employers' Fax #:__________________________(we will be sending work status to this #)

Insurance Carrier:____

Insurance Address:____

Policy or Claim #:_______________________ Adjuster Name:_________________________

Insurance Phone #:______________________ Insurance Fax #:________________________

(Need for all referral services)

Please check authorized services:

□**Initial Injury Evaluation**

□ **Post Accident Urine Drug Screening**

- □7 panel + Alcohol
- □5 panel instant
- □10 panel + Alcohol
- □10 panel instant

Please list the following correspondence that will be needed.

□Doctors First Report □Work Status □PR-2s (for every visit after initial)

□Other : ____

Authorizing Signature:____ **Date:**_________