SPRINGFIELD CLINIC
Leading the Way

Main Campus
1025 South 6th Street
Springfield, IL 62703
217.528.7541

www.SpringfieldClinic.com

WORKERS' COMPENSATION
ACCIDENT REPORT/ SPECIAL BILLING

Office Use Only:
Date Workers' Comp Authorization Signed: _______________
Case Number: ______________________________
MRN: ________________

Date: __________________

Name: ______________________________ Employer: ______________________________

Patient Address: ______________________________ Employer Address: ______________________________

______________________________ ______________________________

Patient Phone Number: ___________________ Employer Phone Number: ____________________

Date of Birth: ______________________ Type of Work: ______________________________

PLEASE CHECK ONE OF THE FOLLOWING

☐ AUTO ACCIDENT

☐ BUSINESS BILLING: ______ Employment Physical ______ Pre-Employment Physical ______ Occ Med

☐ MISC SPECIAL BILLING: _____Workers' Comp _____ Personal Liability

☐ OTHER (please specify): ______________________________

Date of Accident: ______________________

Where: ____

How:

Bill To: ____

____

____

Bill To Phone Number: ________________________ Contact Person: ______________________________

PATIENT SIGNATURE: ______________________________

Any Questions - Please Call Work Comp Representative, Patient Accounting Department 391-0747

White Copy: Patient Accounting Yellow Copy: Ancillary Pink Copy: Review

9422-02/10