OccMed Consulting and Injury Care, LLC
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Worker Compensation Information Form

Note: OccMedCIC does not accept MA DIA rates as payment in full*

PLEASE RETURN COMPLETED FORM TO: occmedcic@OccMedCIC.com

Employee/Employer/Worksite Information:

Name of Employee: _____ Date of Birth: _____ Date of Injury: _____
Direct Employer: _____ General Contractor (❑N/A): _____
Worksite: _____ Safety Manager: _____
Safety Mgr phone: _____ Safety Mgr email: _____

Who is responsible for paying for this worker's care?

❑Direct Bill (with notification to WC carrier) or
❑WC Insurance Carrier via ❑Employer ❑C-CIP ❑O-CIP

Direct Bill/Balance Bill to:

Company Name: _____
Attention to: _____
Address 1: _____
Address 2: _____
City, State Zip Code: _____
❑Send invoice via email to: _____

Worker Compensation Insurance Carrier:

Name: _____
Address 1: _____
Address 2: _____
City, State, Zip Code: _____

Adjuster Name: _____
Adjuster Phone: _____
Adjuster Fax: _____
Adjuster Email: _____
Claim Number: _____

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***Note:**
1. ***Follow-up care is contingent on this form being completed and returned as soon as possible after receipt.***
2. ***If employer decision-makers have not had the opportunity to discuss the value proposition of care via OccMedCIC, please contact Dr. John Burress at jburress@OccMedCIC.com***
3. ***Negotiated non-DIA rates are an unfortunate imperative given the current Mass WC System; we ask the employer to partner with us to ensure that the full invoice is paid directly, or the balance is paid in full after WC DIA rate insurance payment. For a list of our non-DIA rates or questions, please email occmedcic@OccMedCIC.com***