United Interventional Pain Management Center

Form Completed By: ____

Date Form Completed: ____

WORKER'S COMPENSATION, AUTO OR PI CASES

Primary Care Provider: ____

Patient Name: ____ Date of Birth: __1__ __/ ___
(Last and Suffix. i.e. S. Jr) (First) (.11)

Social Security: Part of body injury relates to: ____

ATTORNEY INFORMATION

ATTORNEY NAME: ________________________________ **PHONE #:(___)** ______________

Firm Name: ____

Address: ____

City: ____________________ State: ______ Zip: ________

Services due to:

_______**Workers Compensation** **Date of Injury:** ______________

Employer Name: ____

Employer Address ____

Send Claims to: ____

Mailing Address: ____

City: ____________________ State: _____ Zip: ________ Phone#: ____) ______________

Contact Name (Adjustor): ______________________ Claim #______________________

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Services due to:

______ **Auto Accident**

Date of Injury: __________________ Passenger or Driver (circle one)

Patient's Auto Insurance: ____

Mailing Address: ____

City: _________________________ State: _____ Zip: __________ Phone#: (_) _____________

Contact Name (Adjustor): _____________________________ Claim # _____________________________

Policyholder Name: _________________________ Address: ______________________________

City: ___________________ State: ________ Zip: __________ Phone: (

Name of **Liable Party** (At Fault ❑driver) ____

Address: ________________________ City: __________________ State: ______ Zip: ________

Relationship to Policyholder: ______________

Liable Party's Auto Insurance: ____

Mailing Address: ____

City: _________________________ State: _____ Zip: __________ Phone#: (_) _____________

Contact Name (Adjustor): _____________________________ Claim # _____________________________

Policyholder Name: _________________________ Address: ______________________________

City: ___________________ State: _______ Zip: ___________ Phone: (___) ____________

Services due to:

________ **Personal Injury** **Date of Injury:** ______________

Send Claims to: ____

Mailing Address: ____

City: _________________________ State: _____ Zip: ________ Phone#: (_) _____________

Contact Name (Adjustor): _____________________________ Claim # _____________________________

Liable Party Location: ____

Mailing Address: ____

City: __________________________ State: ______ Zip: ________ Phone#: (   ) _____________