

# Worker's Compensation Claim and Billing Information



Please fill out as much information as possible or submit to your Human Resources department to return to expedite the processing and payment of your work comp claim.

Date Seen: \_\_\_\_\_ Date of Injury/Accident: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Clinic Visited: ☐ HPW ☐ Hillside ☐ Tallgrass ☐ Moline ☐ Cedar Vale ☐ Dexter ☐ Other: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Mailing Address: \_\_\_\_\_

Human Resources Contact: \_\_\_\_\_

Human Resources Phone Number: \_\_\_\_\_

Work Comp Carrier: \_\_\_\_\_

Work Comp Contact/Adjuster Name: \_\_\_\_\_

Work Comp Mailing Address: \_\_\_\_\_

Work Comp Contact Phone Number: \_\_\_\_\_

Claim Number: \_\_\_\_\_

**Please return with a copy of the patient's driver's license:**

Return by fax to: (620) 221-3594  
Attn: Clinic Billing

Return by mail to: William Newton Hospital  
Clinic Billing  
1230 E 6th Ave, Ste 1B  
Winfield, KS 67156

**We appreciate your compliance in obtaining and submitting this information to us in the next 3 days. Otherwise, your account will remain self-pay and move toward a collection agency until the information is received.**