CNS
COMPREHENSIVE NEUROLOGY SERVICES

Worker's Compensation and Accidental Insurance Information:

Worker's comp/accident insurance name: _____

Phone number: _____

Address for claim submittal: _____

Claim #: _____

Adjustor name: _____

Injury date: _____

Type of injury: _____

Adjustor phone number: _____

Adjustor fax number: _____

Law office: _____

Representative's name: _____
Phone number: _____

Fax number: _____

I certify that the above information is accurate and correct:

_____

(Print Name)(SEAL) Date

_____

(Signature) (SEAL) Date

_____

(Parent/Guardian/POA Signature) (SEAL) Date