Maryland Primary Care Physicians

Maryland Primary Care Physicians, LLC
P.O. Box 1590
Millersville, MD 21108
410-729-2642 443-679-1386 (fax)

WORKER'S COMPENSATION FORM

Instructions: The following information must be complete and accurate in order for MPCP to submit this claim.

1. First Name	MI	Last Name

2. Home Phone Number	MPCP Account #

3. Mailing Address

4. SSN	5. Sex	6. DOB	7. Occupation

8. Employer's Name	9. Employer's Phone Number
10. Employer's Mailing Address	11. Contact Person

12. Employer's Worker's Comp Insurance Carrier Name	Employer's Worker's Comp Insurance Carrier Address	
Employer's Worker's Comp Insurance Carrier Phone #	Contact	Worker's Comp Claim #

Is this the only Worker's Compensation case you have filed for this accident? If no, please give additional claim number here:

13. Date of Injury	Time	Location	Body Part Injured

14. Name of Supervisor	Phone Number	Have you given him/her notice of injury? ☐Yes ☐No

15. Describe in detail how the accidental injury occurred.

16. Were you taken to the ER or admitted to the hospital? ☐Yes ☐No	If yes, please give the name and address of the hospital

17. If an attorney is representing you in this case, please provide the name, address, and phone number here:

NOTE: MPCP will need your most recent primary health insurance information, even if on file already. Please provide the information requested below, as well as your health insurance card. This information is necessary for filing your claim if it should be denied by WCC.

ATTENTION MPCP STAFF: Please copy and attach the patient's health insurance card, front and back.

18. Name of Insurance Carrier	Address for claims	Phone

19. I.D. Number	Group Number	Subscriber's Name

I UNDERSTAND AND AGREE THAT

1) Services are being provided to me in reliance upon my representation that I am in fact eligible for Worker's Compensation Benefits.
2) If it is later determined that I am not eligible to receive benefits for these services through WCC, I will be held personally responsible for payments to MPCP for services received.

Signature of Patient or Parent (if minor) ______________________________ Date ____________

RECORDS RELEASE AUTHORITY

I, ______________________, hereby request MPCP provide in writing to my employer and all their agents in this claim a report of my diagnosis, treatment, prognosis, and recommendations as well as other data pertinent to treatment, beginning with the date indicated above in Box 13, including all dates pertinent to this incident.

Signature of Patient or Parent (if minor) ______________________________ Date ____________

MPCP OFFICE USE

Verified by:____________________ Contact Name:____________________
Date Verified:____________________ Contact Phone#:____________________