Worker's Compensation Insurance Verification

2BWell Clinic
5935 Willow Ln
Lake Oswego, OR
97035
Phone: (503) 655 - 0044
Fax: (503) 515 - 8099
www.2bwell.net

Date:	

Patient Name:	
Address:	
City, State, Zip:	
Phone Number:	
Date of Birth:	

Worker's Compensation Information

Insurance Company:	
Adjuster's Name:	
Adjuster's Phone Number:	
Claim Number:	
Date of Injury:	

Employer's Information

Name of Company:	
Address:	
City, State, Zip:	
Supervisor's Name:	
Phone Number:	

I understand that I am personally responsible for all charges by my provider whether or not paid for by the insurance and guarantee payment of the bill. I authorize payment of the medical benefits directly to the provider.

Signature of Patient or Parent/Guardian: _____ Date: _____