WORKER'S COMP FORM - COVERPAGE

We look forward to your upcoming Worker's Comp Visit at Desai Medical Center

Please complete and submit the WC Form before your visit.

This will help expedite your appointment and reduce physical interactions at the office.

PDF PAGE #	FORM TYPE	NOTES/INSTRUCTIONS Do not leave any blank responses – put "None" or "N/A"
1	Coverpage	• Outline and instructions for Physical Forms
2	WC Form	• Fill out the entire form • If you have a Claim Approval Letter from the WC insurance, please submit a copy of the letter

Forms should be filled out electronically

- Use *Adobe Reader*
  - Open the PDF in Adobe Reader
  - Go to *Tools*
  - Select *Fill & Sign*
- After you complete your forms, make sure to add your name (LAST, First) in the file name when you *Save*

If you do not have Adobe Reader, download it for free, https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html

Forms should be submitted electronically

- Use *MedTunnel*
  - Log in to MedTunnel with your ID and PW
  - Click *Compose Message*
  - In the *To* field – Enter our MedTunnel ID, DesaiMedicalCenter
    - If it says "No matches found" – ignore it
  - In the *Message* field – Type any message you want to send
  - In the *Attachments* section – Drag and drop the files you want to send
  - Click *Send*

If you do not have a MedTunnel ID, sign up for free, https://server.medtunnel.com/SignUp.aspx#form1

Desai Medical Center
Worker's Compensation Form

In order to file your visit(s) to a WC insurance, ALL fields must be completed. Please write legibly.

Last Name: ________________________ **First Name:** ________________________

DOB: _____________________ **SSN:** ________________________________

Contact #: __________________________ **Home / Mobile / Work**

Email: __________________________________@____________________

Date/time of Incident: ______________________ **City/State of Incident:** ________________________

How did you get injured? ____

What body part(s) were injured? ____

Prior Healthcare Visits? ☐ Yes ☐ No **Where:** __________________ **When:** __________________

If you have received a Claim Approval Letter from the Worker's Comp insurance, please provide a copy with this form.

Employer: ____

Employer's Address: ____

Worker's Comp Insurance: _________________________________

Has a Claim has been filed to the Worker's Comp Insurance? ☐ Yes ☐ No

Approved Claim #: ____

Approved Body parts: ____

Agent's Name: _________________________ **Agent's Phone #:** _____________________________

Claims Address: ____

Attorney's Name: _______________________________ **Case #:** _________________________

Attorney's Phone #: _________________________ **Attorney's Fax #:** _________________________

- I understand that Desai Medical Center will file my visit(s) to my health insurance if this form is incomplete or I do not provide the necessary claim-filing information for the WC Insurance.
- I understand that I am financially responsible for any unpaid charges, regardless of insurance or third-party coverage.

____ __________________________________

Signature Date

____ __________________________________

Print Date