Dr. Wilbur Kuo and Associates Internal Medicine
Worker's Compensation Waiver and Claim Information

Patient Name: _____

Date of Injury: _____

Employer's Name: _____

Employer's Phone #: _____

Employer's Address: _____
City: _____State:_____Zip:_____

Claim Number: _____

Contact person: _____

Workman's Comp Ins Company: _____

Workman's Comp Ins Phone #: _____

Workman's Comp Ins Address: _____
City: _____State:_____Zip:_____

Claim Rep. Name: _____

I authorize payment of medical benefits to Dr. Wilbur Kuo and Associates Internal Medicine, LLC for services provided.

If the claim has not been paid within 90 days from the date of service, I understand that I will be required to pay the balance in full.

_____

Patient Signature Date