ALASKA HAND REHABILITATION
THERAPY FOR THE SHOULDER, ARM & HAND

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Worker's Compensation Information

ALL FIELDS ARE REQUIRED in order to bill your worker's compensation insurance. Please contact your employer or adjuster for any missing information.

Last Name: _____ First Name: _____ MI: _____

DOB: _____

Occupation/Job Title: _____

Employer: _____

Employer Address: _____

Employer Phone Number: _____

Insurance Company: _____

Claims Address: _____

Claim Number: _____

Adjuster Name: _____ Adjuster Phone Number: _____

Date of Injury (*Must* Match Date Listed on Claim): _____

Please describe the body part(s) injured and the cause of the injury:

_____ _____

Patient or Guarantor Signature | Date

_____ _____

Patient or Guarantor Name Printed | Relationship to Patient