PIIM Worker's Comp. Registration Form

Today's Date:

Patient: Account #:

Has this injury been reported to your employer?

Patient's Employer:
Employer Address: Employer Phone:
Contact at Employer's office:

Date of Injury:
Worker's Compensation Claim #:

Worker's Comp Carrier that employer uses:
Carrier Claim Address:
Carrier Phone: Carrier Fax:
Claim Adjuster or Contact Name:

Is this claim in dispute or is there an attorney involved in this case?
Name: Phone:

Any Additional Info:

Person completing this form: