Community Eye Care of Indiana

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Community Eye Care of Indiana - Work Comp

Patient Information:
Patient Name _____SS#_____DOB_____

Patient Account # _____

Employer Information:
Patient's Employer _____

Employer Contact Name_____

Employer Contact's Telephone #_____

Employer's Fax #_____

Brief Description of Injury_____

Date of Injury_____

Work Comp Information:
Work Comp Carrier Name_____

Work Comp Address (Claims Address)_____

City _____State ____Zip _____Phone #_____

Fax # _____Claim # _____

Work Comp Case Manager or Contact Name _____
In the event this occurrence is NOT considered a covered service by the work comp carrier, I understand I am responsible for all services rendered.

Signature of Patient _____ Date _____

EAST OFFICE
1400 North Ritter, Ste 281
Indianapolis, IN
Phone 317.357.8663
Fax 317.357.8842

NORTH OFFICE
7250 Clearvista Drive, Ste 180
Indianapolis, IN 46256
Phone 317.594.9410
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