

**Capital Medical Clinic**  
4701 Normal Blvd Lincoln, Nebraska 68506  
Phone 402-488-5050 Fax 402-488-5001

**Workman's Compensation Billing Information**

**In order for us to file your Workman's Compensation claim, you must provide all necessary information as listed below. If the information is not provided in 2 days, we reserve the right to bill you for all services.**

**NAME** \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ SSN \_\_\_\_\_  
**Injury Claim #** \_\_\_\_\_ **Date of Injury** \_\_\_\_\_  
**Brief Description of Injury** \_\_\_\_\_

**EMPLOYER** \_\_\_\_\_ Work# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Contact Person \_\_\_\_\_ Contact# \_\_\_\_\_

**SUBMIT CLAIMS TO** \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Contact Person \_\_\_\_\_ Contact# \_\_\_\_\_

**NAME OF LAWYER** (if applicable) \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

**HEALTH INSURANCE** \_\_\_\_\_ ID# \_\_\_\_\_

- I understand that Capital Medical Clinic will file claims on my behalf.
- I authorize the release of any medical information necessary to process my claims.
- I understand that I am responsible for payment of all services provided to me by this clinic.
- If I am unable to provide all necessary information at this time, I agree to provide it within 2 days of this appointment.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*(Revised 05/2014)*