MILL CITY MEDICAL GROUP
595 Pawtucket Blvd 2nd floor
Lowell, MA 01854
(978) 955-9500

WORKMEN'S COMPENSATION AUTHORIZATION FORM

EMPLOYEE: ___________________________________ **DOB:** _______________

EMPLOYER: ____

ADDRESS: ____

______________________, _____ _____________

CONTACT: _________________________________ **PHONE:** ________________

DATE OF INJURY: ____

EXPLANATION OF INJURY: ____

WORKMEN'S COMPENSATION INSURANCE INFORMATION

NAME: ____

ADDRESS: ____

_____________________, _____ ______________

PHONE: ____

ADJUSTER'S NAME: ____

ADJUSTER'S PHONE: ____

CLAIM/FILE NUMBER: ____

OTHER INFORMATION YOU FEEL IS NECESSARY TO PROCESS YOUR CLAIM

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I AUTHORIZE MILL CITY MEDICAL GROUP TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MEDICAL CLAIMS PROVIDED BY THE PHYSICIAN. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN FOR SERVICES PROVIDED.

SIGNATURE: _____________________________________ **DATE:** _______________