



CENTER FOR WORK INJURIES
Another service from the Center for Orthopaedics & Sports Medicine

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Work Comp Billing Information Form

Patient Name: _____

Address: _____

Phone #: _____

Date of Birth: _____ **SS#:** _____

Date of Injury: _____ **Claim#** _____

Employer: _____

Address: _____

Phone#: _____ **Fax#:** _____

WC Insurance Carrier: _____

Billing Address: _____

Phone#: _____ **Fax#:** _____

Nurse Case Manager: _____ **Phone#** _____ **Fax#:** _____

If the patient does not have this information, it is their responsibility to obtain it or the bills will be sent to them.

