

***Robinwood Orthopaedic Specialty Center*** \_\_\_\_\_

Drs. Edwards, Holobinko, Kosuri & Patterson  
Drs. Sherman, Winslow & Worrell

Workers Compensation Information

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Account: \_\_\_\_\_

If you were involved in a work related accident, we must bill your employer's workman's compensation carrier. We may not bill your health insurance unless the workman's compensation carrier has denied your claim. If that is the case, please inform us immediately and provide our office with a copy of the letter of denial.

Name of Employer: \_\_\_\_\_

Employer's Phone Number and contact: \_\_\_\_\_

Name of Work Comp insurance company: \_\_\_\_\_

Address: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Date of Loss: \_\_\_\_\_

Case Manager and phone number: \_\_\_\_\_

You must first notify your employer of your accident, and then contact us at 301-302-0472 with the above information if not available upon arrival in our office.

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