McLaren Business Products

McLaren Print System Order

Order No: 43611 Reprint Previous Order No: 24583
Order Date: 2019-03-15
User: REIN HIGGINS
Phone: 517-913-3810

Ship Location: MMP-MCLAREN HEALTHCARE ASSOCIATES --ATTN: REIN
1540 LAKE LANSING ROAD,SUITE 102
LANSING MI 48912,
Forms
Quantity: 500
Paragon Dept No: 68100
Dept Name: MCLAREN HEALTHCARE ASSOCIATES
Company Number: 810

Order Total Price: 0.00

Item Number: MM-348
Item Description: Injury Intake Form
Revision Date: 8/2016
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info: ss; black

McLaren Medical Group
INJURY INTAKE FORM

Please select one of the following: ☐ Auto ☐ Worker's Comp ☐ Other Accident

Name:	Date of Birth:	Social Security#:
Date of Injury:	Was Injury Reported? ☐ Yes ☐ No If yes ☐ Verbal or ☐ Written Who took the report?	
Please Describe your injury:	Police Report#	

Workers Compensation Information:

Workers Comp Company Name and Address:

Caseworker Name:	Phone Number:	Claim Number:

Employer Name and Address: Supervisor Name & Phone#:

Has a form 100 Been filed? ☐ Yes ☐ No If yes, please provide a copy of the form 100.

Auto Accident Information:

Auto Carrier Name and Address:

Caseworker Name:	Phone Number:	Claim Number:

Do you have medical insurance? ☐ Yes ☐ No
If yes, is your medical insurance the primary payer to your auto insurance?

Were you the driver or passenger in the vehicle?

Other Accident Information:

Where did the accident occur?
Are you an employee of this location? ☐ Yes ☐ No

Do you have other outstanding auto or workers comp claims?: ☐ Yes ☐ No

If yes, please provide the following information:
Is this case still in dispute? ☐ Yes ☐ No Is an attorney involved? ☐ Yes ☐ No

If yes, please list attorney information below: Attorney's name, address and phone#:

Is your employer/caseworker aware you are seeing this attorney? ☐ Yes ☐ No

I understand that I am ultimately responsible for payment of services rendered to me. I also understand that Mclaren Medical Group will bill the Auto and/or Worker's Compensation Carrier for any related services performed by the provider. I agree that I have provided any and all of my health insurance information to Mclaren Medical Group. In the situation where the Auto and/or Worker's Compensation Carrier denies payment, I understand the provider is entitled to bill my health insurance. In the event my health insurance does not pay these claims, I understand that I will be responsible for my payment of those services. I also understand that in the event of a new injury, I will inform Mclaren Medical Group of any new information needed for billing purposes.

Signature _____ Date and Time: _____