ARGOS VISION AND EYECARE CENTER

15920 Shady Grove Rd
Gaithersburg, MD 20877
Tel. (301) 637-3181
Fax (301) 637-5242

WORKER COMPENSATION FORM

PLEASE FILL OUT IN ITS ENTIRETY

PATIENT'S NAME: _____

EMPLOYER: _____

CONTACT PERSON & NAME OF WORKERS COMPENSATION COMPANY:

_____

_____

PHONE NUMBER OF CONTACT PERSON: _____

FAX NUMBER OF CONTACT PERSON: _____

CLAIM NUMBER: _____

DATE OF INJURY: _____

CLAIM FILING ADDRESS: _____

_____

DOES WORKERS COMP REQUIRE A SPECIFIC DIAGNOSIS FOR CLAIMS? IF SO, PLEASE GIVE SPECIFIC DIAGNOSIS: _____

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