The Specialist Orthopaedic Centre

THIRD PARTY / WORKERS COMPENSATION

CLAIM DETAILS

Phone: 02 6675 0737 Fax: 02 6619 5450

Name..

Address...

Date of birth.......................Home phone...............................

Mobile....................................Work phone.........................

Referring Doctor..

Employer..

Occupation: ....Phone...............................

Claim number..........................Date of injury...........................

Insurance Company...

Contact person...

Phone.......................................Fax..............................

Email address..

I hereby give permission for The Specialist Orthopaedic Centre to access or obtain relevant medical information from any other health provider or ancillary service provider and to provide any relevant reports to be forwarded to my insurance company on my condition/claim.

Signature...Date....................