Specific Case Information Worksheet:

Claimant/Plaintiff:

Name:
Address:
SSN/HICN:
Telephone Number:
Gender:
Medicare Coverage Parts: Part A: □ B: □ C: □ D: □
(Check all that apply and provide copy of Medicare card)
Date of Injury:
Date of Birth:
Body Part(s)/System(s):

Claimant's Attorney

Name:
Address:
Telephone Number:

Employer/Defendant

Name:
Address:

Insurance Carrier

Name:
Address:
Claim Number:

Insurance Attorney
Name:
Address:
Telephone Number: