Work Related Temporary Account Form

Your company has not established an account with Texas MedClinic for the treatment of work related injuries. As such, a staff member has referred you to our website to print out the is form. In order for our physicians to treat your employee's work related injury, this form needs to be completed.

After completing the required information on this form you can:

- Fax the form to the clinic your employee will be using
- Or have the injured employee bring the form to the clinic

Without this completed form we will not be able to treat your employee's work related injury. Our physician will ensure that the employee is medically stable and he/she will be referred to the emergency room for further evaluation and treatment.

San Antonio/Selma

Loop 410/Broadway
Ph: 210.821.5598
Fx: 210.341.7513

IH –35/Eisenhauer
Ph: 210.655.5529
Fx: 210.655.5504

IH –35/Loop 1604
Ph: 210.659.5533
Fx: 210.698.6627

Blanco/Parliament
Ph: 210.341.5588
Fx: 210.341.7513

Wurzbach/Colonnade
Ph: 210.696.5599
Fx: 210.699.8152

Loop 410/Ingram
Ph: 210.520.5588
Fx: 210.522.1125

Bandera/Loop 1604
Ph: 210.694.4884
Fx: 210.695.4949

Leon Springs/IH 10
Ph: 210.698.6617
Fx: 210.659.7755

Hwy 151/Loop 410
Ph: 210.682.5577
Fx: 210.647.5566

SE Military/Roosevelt
Ph: 210.927.5580
Fx: 210.927.2700

Stone Oak/1604
Ph: 210.549.5893
Fx: 210.549.5894

New Braunfels

IH 35 N/Hwy 46
Ph: 830.606.5533
Fx: 830.606.5535

Patient Name:______________________________

DOB: _____________

Claim # (optional):______________________

New Account Billing Information - Work Related Injuries

In order to treat your work related injury, Texas MedClinic must obtain the billing information for either your employer or your employer's Workers Compensation insurance. State laws set forth by the Division of Workers Compensation prohibit medical providers from billing or accepting payment from the patient for the treatment of work related injuries if the company has Workers Compensation Insurance. If we cannot determine if your employer has insurance for work related injuries our physician will only ensure that you are medically stable and you will be referred to the emergency room for further evaluation and treatment.

Employer Information: All information is required for this section

Company Name: ____

Address: ______________________________

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City: ______________________________

State: ______________ Zip code: ______________

Company Contact: ______________________________ Phone: ______________

Email: ______________________________ Fax: ______________

Billing Information: Select one of the following options, all items that have an * are required.

Information provided by*: ______________________________ Date*: ______________

☐ **Bill our Workers Compensation Insurance**

Name of Insurance*: ______________________________

Is the company in the Network*: ☐ Yes ☐ No

Name of Network*:

____

Insurance Address/Phone number (Optional):

____

____

☐ **Bill our company, we do not carry Workers Comp Insurance**

Company Name*: ______________________________

Is the company in the Network*: ☐ Yes ☐ No

Name of Network*:

____

Company Billing Address*:

____

____

City: ______________________________

State: ______________ Zip: ______________

How did you hear about Texas MedClinic? ______________________________