



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

Austin

IH-35/Slaughter Ln

Ph: 512.291.5577

Fx: 512.291.5576

MoPac/Parmer

Ph: 512.835.5577

Fx: 512.836.0166



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: _____ 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*: _____

Insurance Address/Phone number (Optional):

Is the company in the Network*: Yes

No

Bill our company, we do not carry Workers Comp Insurance

Company Billing Address*:

Company Name*: _____

Is the company in the Network*: Yes

No

Name of Network*: _____

City: _____
 State: _____ Zip: _____

How did you hear about us? _____