Work Related Temporary Account

Your company has not established an account with Texas MedClinic for the treatment of work-related injuries. For our providers 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
- 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 providers will ensure that the employee is medically stable, and they will be referred to the emergency room for further evaluation and treatment.

Locations

FORUM IH 35 N / Loop 1604 **(24 Hour)**

Ph: (210) 659.5533 | Fx: (210) 659.7755

occmed.fm@texasmedclinic.com

WURZBACH IH10 W/ Wurzbach **(24 Hour)**

Ph: (210) 696.5599 | Fx: (210) 699.8152

occmed.wz@texasmedclinic.com

CULEBRA Loop 1604 / Culebra **(24 Hour)**

Ph: (210) 476.5577 | Fx: (210) 688.9334

occmed.cu@texasmedclinic.com

BANDERA Loop 1604 / Bandera

Ph: (210) 695.4884 | Fx: (210) 695.4949

occmed.bn@texasmedclinic.com

BLANCO Blanco / Parliament

Ph: (210) 341.5588 | Fx: (210) 341.7513

occmed.bl@texasmedclinic.com

BROADWAY Loop 410 / Broadway

Ph: (210) 821.5598 | Fx: (210) 829.0125

occmed.br@texasmedclinic.com

DOVE CREEK 1604/Potranco

Ph: (210) 476.5581| Fx: (210) 626.8003

occmed.dc@texasmedclinic.com

EISENHAUER IH 35 N / Eisenhauer

Ph: (210) 655.5529 | Fx: (210) 655.5504

occmed.es@texasmedclinic.com

INGRAM Ingram/Loop 410

Ph: (210) 520.5588 | Fx: (210) 522.1125

occmed.ig@texasmedclinic.com

LEON SPRINGS IH 10 W / Leon Springs

Ph: (210) 698.6617 | Fx: (210) 698.6627

occmed.ls@texasmedclinic.com

SINGING HILLS Hwy 281/Hwy 46

Ph: (830) 632.5740 | Fx: (830) 632.5743

occmed.sh@texasmedclinic.com

SOUTHEAST SE Military / Roosevelt

Ph: (210) 927.5580 | Fx: (210) 927.2700

occmed.se@texasmedclinic.com

SOUTHWEST SW Military / Zarzamora

Ph: (210) 476.5599 | Fx: (210) 455.9217

occmed.sw@texasmedclinic.com

STONE OAK 1604 / Stone Oak Pkwy

Ph: (210) 549.5893 | Fx: (210) 549.5894

occmed.so@texasmedclinic.com

STOTZER Hwy 151 / Loop 410

Ph: (210) 682.5577 | Fx: (210) 647.5566

occmed.sz@texasmedclinic.com

NEW BRAUNFELS IH 35 N / Hwy 46

Ph: (830) 606.5533 | Fx: (830) 606.5535

occmed.nb@texasmedclinic.com

OAK RUN Hwy 46/Oak Run Pkwy

Ph: (830) 632.5092 | Fx: (830) 632.5094

occmed.or@texasmedclinic.com

PARMER N MoPac / Parmer

Ph: (512) 835.5577 | Fx: (512) 836.0166

occmed.pr@texasmedclinic.com

ROUND ROCK IH 35 N / Bass Pro Drive

Ph: (512) 486.6140 | Fx: (512) 863.4285

occmed.rr@texasmedclinic.com

SOUTHPARK MEADOWS IH 35 S / Slaughter Lane

Ph: (512) 291.5577 | Fx: (512) 291.5576

occmed.sp@texasmedclinic.com

Patient Name: ___________________________
DOB: _____________

Claim # (if applicable) ___________________

Received by:___________________________

New Account Billing Information - Work Related Injuries

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 items that have an * are required.*

***Company Name:** ____

***Address:** ____ ***City:** ____

____ ***State:** __________ ***Zip code:** __________________________

***Company Contact:** ______________________________________ ***Phone:** ____

***Email:** ____ ***Fax:** ____

Billing Information:

<u>_____Bill our Workers Compensation Insurance</u>

*Name of Insurance: ____

*Is the company in the Network: Yes No *Name of Network: ____

*Insurance Address: ______________________________________ *City: ___________________________*State: _____*Zip:_______

*Insurance Phone: _______________________________________ *Insurance Email:____

<u>_____Bill our company, we DO NOT carry Workers Comp Insurance</u>

*Billing Contact: _______________________________________ *Billing Email:____

*Billing Address: _______________________________________ *City: ___________________________*State: ______*Zip:_________

*Information provided by (company contact):______________________________________ *Date: __________________________

*How did you hear about Texas MedClinic? ____