TERRY J. BEAL, MD

WORKER'S COMPENSATION VERIFICATION

Patient Name: ______________________________
DOB: ______________________ SS# ______________
Patient Address: Street: ______________________________
City, State, Zip: ______________________________
Phone # : ______________________________
Have you seen another doctor? YES ________ No ________
Appointment Date: ______________ Time: ______________

Reason for Visit: Consult: ________ Procedure: ________ Imp Rat: ________
Are we going to become the treating doctor? Yes: ________ No: ________

Employer Name: ______________________________
Employer Address: ______________________________
City, Address, Zip: ______________________________
Phone Number: ______________ Fax#: ______________
WC Verified By: ______________________________
Are you going to file with TWCC Insurance Carrier? Yes: ________ No: ________
Have you filed initial report of injury? Yes: ________ No: ________
Are you self-insured? Yes: ________ No: ________

Date of Inury/Accident? ______________________________
Claim #: ______________________________

Adjustor Name: ______________________________
Adjustor's Phone #: ______________ Fax #: ______________
What diagnosis is compensable for this injury? ______________________________

Treating doctor? ______________________________
Treating doctor phone # ______________ Fax #: ______________

Insurance Carrier Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone Number: ______________ Fax #: ______________

Initial Injury Report Submitted By Employer: Yes: ________ No: ________
TWCC 61 Submitted by Treating Doctor: Yes: ________ No: ________
Patient Submitted Injury Report On What Date: ______________
Should We Submit TWCC 61 or any other reports? Yes: ________ No: ________

Date called TWCC (512)440-3780 ______________
Response : Verified information: ________ Left Message: ________
(BE SURE TO HAVE EMPLOYER NAME, EMPLOYER ADDRESS AND DATE OF INJURY WHEN YOU CALL TWCC.)