MASSOOD LAW GROUP, LLC
WORKERS' COMPENSATION INTAKE SHEET

Date: _____

Patient Name: _____ DOB: _____

Patient Address: _____ SSN: _____

_____ DOA: _____

Medical Provider/Client: _____

Employer Name: _____

Employer Address: _____

Insurance Company: _____ Claim #: _____

Insurance Company Address: _____

Date(s) of Service: _____

☐ Health Information Claim Form (HICF)
☐ Itemized Bill
☐ Denied EOB
☐ Exemplar EOBs*
☐ Operative Report
☐ Medical Records
☐ Signed Application

* In order to justify additional reimbursement, we need sample EOBs showing that other carriers have issued payment at or close to the amounts billed herein for the CPT codes billed herein.

Date(s) of Service	**CPT Code**	**Ingenix Rate**	**Actual Value**	**Amount Billed**	**Insurance Paid**	**Balance**