CHRISTIE CLINIC
We listen. We care.

UHS Work Comp Initial Claim Verification Form

uhs UNIFIED HEALTH SERVICES
Our Work, Your Compensation.

CHRISTIE CLINIC

PLEASE SCAN FORM INTO ECW AND ASSIGN IT TO BS WORKLIST, WC UHS

Date:		**Contact:**	**Special Bill Group**
To:	**Unified Health Services**	**Contact Phone:**	**217-366-1337**
Phone:	**901-271-5500**	**Contact Fax:**	**217-366-2284**
Fax:	**901-869-0943**	**Contact Email:**	SpecialBillingCharge@christieclinic.com

PATIENT INFORMATION

Name:		**Pt Acct#**	
Address:		**Date Of Injury:**	
City, State, Zip:		**Type of Injury:**	
Phone:		**Carrier, if known:**	
Date Of Birth:	**Sex:** ☐ **M /** ☐ **F**	**How did injury occur?**	
SS#:			

EMPLOYER INFORMATION

Employer:		**Contact:**	
Address:		**Has treatment for work-related injury been**	
City/Zip:		**authorized by employer?** ☐ **Yes /** ☐ **No**	
Phone:		**If yes, by whom?**	

Special Instructions