# Initial Claim Worksheet

## Doctors and Hospitals

Please list the doctors and hospitals you have received treatment from since your date last worked

**Name of Doctor / Hospital**

**Complete Address**

**Street Address:**

**City:** **State:** **Zip:**

**Phone #** **Fax #**

**First Visit** **Last Visit** **Next Appt.**

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**Name of Doctor / Hospital**

**Complete Address**

**Street Address:**

**City:** **State:** **Zip:**

**Phone #** **Fax #**

**First Visit** **Last Visit** **Next Appt.**

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**Name of Doctor / Hospital**

**Complete Address**

**Street Address:**

**City:** **State:** **Zip:**

**Phone #** **Fax #**

**First Visit** **Last Visit** **Next Appt.**

## Continuation of Doctors and Hospitals

**Name of Doctor / Hospital**

**Complete Address**

**Street Address:**

**City:** **State:** **Zip:**

**Phone #** **Fax #**

**First Visit** **Last Visit** **Next Appt.**

**Name of Doctor / Hospital**

**Complete Address**

**Street Address:**

**City:** **State:** **Zip:**

**Phone #** **Fax #**

**First Visit** **Last Visit** **Next Appt.**

**Name of Doctor / Hospital**

**Complete Address**

**Street Address:**

**City:** **State:** **Zip:**

**Phone #** **Fax #**

**First Visit** **Last Visit** **Next Appt.**