Kincraig Medical Clinic

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WORKCOVER INFORMATION FORM

Date of Service: _____ / _____ / _____

PATIENT DETAILS

Patient Name: _____

Patient Address: _____

Patient Phone No: _____

EMPLOYER DETAILS

Employer: _____

Employer Address: _____

Contact Person: _____

Contact Phone No: _____

Should my WorkCover claim be unsuccessful, I agree to pay all fees incurred over and above the Medicare rebate for this service.

Signature: _____

Name: _____