❑ **Wallerich Eye Care – St. Paul (Midway)**
1300 University Ave W
Saint Paul, MN 55104
T: (612) 643-3525
F: (612) 299-1452
Email: OM@WallerichEyeCare.com

❑ **Wallerich Eye Care – Eden Prairie**
8225 Flying Cloud Drive
Eden Prairie, MN 55344
T: (612) 643-3525
F: (612) 299-1452
Email: OM@WallerichEyeCare.com

Worker's Compensation Claim

You have been scheduled to see Dr. Michael Wallerich for a neuro-optometric evaluation. He will evaluate your visual skills and evaluate your eye health as related to your brain injury. Completion of this form does not guarantee eligibility and coverage. Ultimately, that is determined by your Worker's Compensation Insurer. Wallerich Eye Care will provide all necessary documentation to you and requested parties (***with written consent only by medical release form***) to support your eye & vision care needs. This form must be completed **prior** to your evaluation. It is advised that you have a ***referral from your treating health care provider & a claim authorization number*** (provided by your Worker's Compensation Insurer) prior to your assessment. All services provided will be billed the usual & customary charges, which is ultimately your responsibility. Wallerich Eye Care will assist you by providing all necessary documents to be able to submit for this visit.

Patient Information (*Patient or Employer to Complete*):

Full Name (Last, First, MI) , ,		
Date of Birth:	Gender: Male ☐ Female ☐ Other:	
SSN:		
Address:		
City:	State:	Zip:
Home Phone :	Work/Cell Phone:	

Worker's Compensation (*Employer to Complete*):

Insurance:	Plan Name:	Phone:
Contact Person:		
Address:		
City:	State:	Zip:
Policy/Claim #:	Authorization #:	
Employer Name:		
Employer Address:		
City:	State:	Zip:
Phone:		
Form Completed by (print first/last names):		
Employer Signature:		
Date:		

=========================Northland Billing BELOW ==============================

Date of Injury:	
☐Patient unable to work	Dates Unable to Work: to
***Able to return to Work Date*:**	
☐Patient able to work a "Limited" schedule	
Number of hours per week:	
Initial Visit Date (not injury date):	
Diagnosis:	
☐Medical Records/Billing Sent to Northland Billing Services	