



“CLAIM INFORMATION PENDING” FORM
(Interim Employer’s Promissory Note for Payment)

Employee/ Patient Name: _____
Date of Injury: _____
Authorized body part(s): _____

Employer Company:
Name: _____
Address: _____
Telephone: () _____ - _____
Facsimile: () _____ - _____
Main contact: _____ **Position in company:** _____

Has a claim been filed for this injury: **YES** **NO**

**Please note that the State of California – Workers’ Compensation Division mandates that all work-related injuries be reported to an industrial insurance carrier. Failure to do so will result in extensive fines and possible imprisonment.*

Insurance Carrier Name: _____
Address: _____
Telephone: () _____ - _____
Facsimile: () _____ - _____
Contact: _____

If “NO”: **When will a claim be filed:** _____
State reason: _____

As an authorized representative of the employing company, I verify the above is true to the best of my knowledge. Until a formal claim for the employee’s condition is processed, I give The Hand and Wrist Center authorization to: **(check one)**

- _____ Consult Only (with x-rays)
- _____ Consult and Treat (with x-rays) (NOTE: If therapeutic or surgical treatment, or other external diagnostic testing is needed, our office will inform you before proceeding with this treatment)

**Please note that our physicians will not address causation issues – please refer to your insurance carrier for further information regarding addressing these issues.*

Person completing this form/contact: _____
Position within company: _____

Printed name of employer representative: _____
Signature of employer representative: _____
Date: _____