INOVA HEALTH SYSTEM
Inova Alexandria Hospital
Worker's Compensation Worksheet

PATIENT INFORMATION:
Patient's Name: Last: ________________ First: ________________ Middle Initial: ______
Date of Birth: ________________ Social Security Number: __________________________
Home Address: ____
Home Phone Number: __________________ Work Phone Number: _________________

ACCIDENT INFORMATION:
Date of Injury: _________________ Time of Injury: ________________________ AM/PM
How did accident happen: ____
Physical Location of accident: ____
Was this reported to Employer: Yes / No If so, Date: _________ Time: ___________
Person and title notified: ____
Pre-existing work related injuries (explain): _______________________________________
Info previously submitted? ____

EMPLOYER INFORMATION:
Name of Employer: Alexandria City Public Schools
Address: 1340 Braddock Place, Alexandria, VA 22314
Contact Person: Human Resources Phone Number: 703-619-8010/Fax-703-619-8983

WORKER'S COMPENSATION INSURANCE CARRIER:
Name of Insurance Carrier: CorVel Corporation
Address: P.O. Box 44015, Baltimore, MD 21236
Claim #: _________________ Adjuster's Phone Number:______________________

HEALTH INSURANCE INFORMATION:
Name of Insurance Company: N/A
Policy/Identification #: N/A Group #: N/A
Phone Number: N/A
Claims Mailing Address: N/A
Subscriber's Name: ____
Subscriber's Date of Birth: ____________ Social Security #: ___________________
Subscriber's Employer's Name: ____
Subscriber's Employers Address: ____
Subscriber's Phone Number: ____

Send completed form and copy of insurance card (both front and back) to:

Inova Alexandria Hospital
Registration Department
4320 Seminary Road
Alexandria, VA 22304
Phone Number: 703-504-3166 Fax Number: 703-504-3224