VIRGINIA GATEWAY URGENT CARE CENTER

7516 Iron Bare Lane
Gainesville, VA 2011
703-754-9111
703-754-1211 FAX

Patient Name: _____ Date _____

Employer: _____ _____

Reason for Visit: _____

Visit Approved by: _____

Employer Address: _____

Employer Telephone No.:_____

Employer Fax No.:_____

Date of Injury: _____

Was injury sustained while working: Yes No

Will patient be required to perform a drug screen: Yes No

If yes:

- 5 Panel
- 10 Panel
- Other _____

Worker's Compensation Insurance:

Name of Company: _____

Policy No.: _____

Claim No. (If Filed): _____

Claim Adjuster: _____

Insurance Carrier's Phone No.: _____

Insurance Carrier's Fax No.: (fax ITR each visit) _____

Billing Address (To Send Claims): _____

_____

REV 11/15