MIDWEST OCCUPATIONAL MEDICINE LTD

SERVICE AGREEMENT

Billing Information:

Company Name _____ Contact Name _____

Address _____

Phone _____ Email _____ Fax _____

Printed Name Company Representative _____

Signature of Company Representative _____

Workers Compensation Insurance Information:

Company Name _____ Contact Name _____

Address _____

Phone _____ Email _____ Fax _____

By signing this document the company acknowledges they are responsible for payment of all services that Midwest Occupational Medicine Ltd. performs on their employee. This includes payment for any claim the employer's Workers Compensation Insurance carrier denies payment for.

Wood River
325 Madison (Hwy 143)
Wood River, IL 62095
Ph: 618-251-5202
Fax: 618-251-5118

IMPORTANT: Please fully complete your form, save the file to your computer, and email your completed form to greeves@midwestoccmed.com and tjurcich@midwestoccmed.com.