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 the emails listed at the top of midwestoccmed.com/forms.