EYE SURGERY &
LASER CENTER
Anthony Novak, M.D.
Board Certified Specialty Eyecare

WORK COMP FORM

Please complete the following information:

Date: _____

Name: _____ DOB: _____

Address: _____

Phone #: _____

Employers Name: _____

Address: _____

Phone #: _____

Contact Person: _____

Date of Injury: _____

Work Comp Insurance Company Name: _____

Claims Address: _____

Work Comp Phone #: _____ Fax #: _____

Work Comp Claim #: _____

Work Comp Contact Person: _____

Please complete the above information, if you do not have all of the information requested, please give to your employer to complete, and return to Eye Surgery and Laser Center at 183 East Pomeroy St. River Falls, WI 54022 or fax to 715-425-6001. **The patient will be responsible for any bills or charges until we receive all pertinent information**.