PBOS Rx
PHARMACY BILLING OPTIMIZATION SERVICES

Workers' Compensation Patient Intake Form

Patient Information

Patient's Name: _____
Last First MI

Patient's Address: _____ _____ _____ _____
Street City State Zip

Sex: M F SSN#_____-_____-_____ Date of Birth: ____ / ____ / ____

Patient's Phone: (_____) _____-_____ Date of Injury: ____ / ____ / ____

Claim #: _____ ICD-10 Code(s): _____

Insurance or Employer Information

Work Comp Carrier: _____

Insurance Carrier Address: _____

Insurance Carrier City: _____

Insurance Carrier State: _____ Insurance Carrier Zip: _____

Adjuster Phone: _____

If you need assistance with transmitting a claim or have any questions, please contact us at

Help Desk 888-727-8879 **Fax 844-897-5966** **support@pbosrx.com**