Workers' **C**ompensation **I**nformation **C**ard

Employer: **V**anderburgh **C**ounty

Department:

Employee Name:

Date of Injury:

EMPLOYEE: To ensure correct and prompt payment of bills, you must present this card to **all medical facilities** where you receive any type of care for your injury. *Use the separate Mitchell Script Advisor card for all prescriptions related to your injury.*

WC Insurance Carrier: **Davies**
Corporate Office: PO Box 291587
Nashville, TN 37229

Adjuster: Kristi Brown
Phone: 502-547-2109
Email: kristi.brown@us.davies-group.com

SEND ALL **BILLS TO**:
Davies
PO Box 2113952
Eagan, MN 55121