OMH N'ORTHOPEDICS
WORKER COMPENSATION CLAIM INFORMATION

NAME: _____SS#: _____

DATE OF INJURY: _____ COUNTY OF INJURY: _____

EMPLOYER: _____ PHONE#: _____

ADDRESS: _____ CONTACT: _____

CITY, STATE, ZIP: _____ AUTHORIZED DATE: _____

HAS YOUR EMPLOYER BEEN NOTIFIED OF THIS INJURY? YES NO
HAS A FORM 100 BEEN FILED? YES NO
IF YES, PLEASE PROVIDE A COPY.
HAS YOUR EMPLOYER OR CASE MANAGER BEEN NOTIFIED
THAT YOU ARE SEEING THIS PHYSICIAN? YES NO

WORKER COMPENSATION CARRIER: _____

CONTACT/CASE MANAGER: _____PHONE #_____

ADDRESS: _____FAX #: _____

CITY, STATE, ZIP: _____

CLAIM NUMBER: _____AUTHORIZATION DATE:_____

IS THIS CASE IN DISPUTE? YES NO
IS AN ATTORNEY INVOLVED? YES NO
IF YES, PLEASE LIST ATTORNEY INFO:

ATTORNEY NAME: _____PHONE #_____
ADDRESS: _____CITY, ST, ZIP: _____

PLEASE DESCRIBE THE TYPE OF INJURY AND HOW IT HAPPENED:

_____

_____

LAST DAY WORKED: _____RETURNED TO WORK DATE: _____

PATIENT FINANCIAL AGREEMENT

I understand that I am ultimately responsible for payment of services rendered to me. I understand that OMH N'Orthopedics will bill the Worker Compensation Carrier of my employer for any authorized services. By authorization this means that your employer is aware of your visit, has approved services and has notified the insurance carrier of your claim of work injury. ***(You, as the patient, are responsible for providing us with an authorization from the carrier before treatment can begin.)*** I agree to provide all of my health insurance information to OMH N'Orthopedics. I understand if the W/C carrier denies payment via ***"Notice of Dispute"*** you will bill my health insurance carrier through subrogation. I understand that I will ultimately be responsible for payment of these services in the event that I do not have health insurance, my claim is denied or my health insurance does not subrogate work related claims.

SIGNATURE: _____DATE: _____

WITNESS: _____DATE: _____