

McKinley
Orthopedic & Sports Medicine

WORKMEN'S COMPENSATION INFORMATION

Patient's Name: _____ Date: _____

INFORMATION REQUIRED TO BILL WORKMEN'S COMPENSATION CLAIMS:

DATE OF INJURY: _____

Employer at the time of the injury: _____

Workmen's Compensation CARRIER: (this is different from your employer)

Workmen's Compensation CLAIM #: _____

Workmen's Compensation Carrier Address: _____

Workers Comp Ins Contact Person: _____ Phone #: _____

AGREEMENT

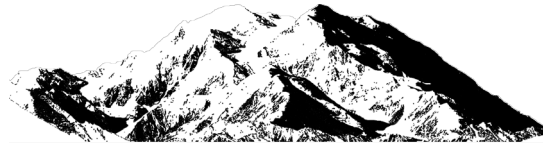
The Undersigned hereby agrees to supply McKinley Orthopedic & Sports Medicine with the above (NEEDED) information within 5 days for the medical services provided to the above-named patient.

***** IN THE EVENT THE ABOVE INFORMATION IS NOT SUPPLIED TO MCKINLEY ORTHOPEDICS & SPORTS MEDICINE WITHIN THE SPECIFIED TIME (5DAYS) OR THE CLAIM IS DENIED BY CARRIER I UNDERSTAND THAT THE ACCOUNT BALANCE WILL BECOME THE GUARANTOR'S IMMEDIATE RESPONSIBILITY *****

Patient Signature: _____ Date: _____

Received by: _____ Date & Time: _____

BACK SIDE STAFF ONLY



McKinley
Orthopedic & Sports Medicine
(STAFF ONLY)

WC INFORMATION CONFIRMATION

Please call the WC insurance to confirm the following information:

PATIENT ACCT# _____

SPOKE WITH: _____ PHONE #: _____

BODY PART COVERED: _____

DATE OF INJURY: _____

WC INSURANCE CARRIER: _____

CLAIM NUMBER: _____

ADJUSTER NAME: _____

ADJUSTER PHONE: _____

CLAIMS MAILING ADDRESS:

Information collected & confirmed by:

X: _____ Date: _____