New York Injured Worker Intake Form

daisyBill

Injured Worker Demographics

Last Name:*	First Name:*	Middle Init:
Date of Birth:*	SSN:	Gender:* F ☐ M ☐
Address:*		
City:*	State:*	Zip:*
Telephone:		

Claims Administrator Information

Claims Administrator Name:*		
Address:		
Adjustor Name:	Telephone:	Fax:
Email:		

Injury Claim Information

Claim Number:*	Injury Start Date:*
WCB Case Number:	Injury Description:
Claim Status: ☐ Accepted ☐ Disputed ☐ Denied ☐ Other	

Employer Information

Employer Name:*		
Address:*		
City:*	State:*	Zip:*

Attending Doctor

Last Name:	First Name:
Practice Name:	Specialty:
Telephone:	Fax:

Injured Worker Referred By

Name:	Company:	Telephone:
Role: ☐ Adjustor ☐ Employer ☐ Applicant Atty ☐ Defense Atty ☐ Other		

Billing Information

Electronic ☐ None	Clearinghouse: ☐ WorkComp EDI ☐ Covel ☐ Jopari ☐ Availity ☐ P2P ☐ Other:
	Payer ID:
Mail	Mail Address:

Additional Notes

Completed By: _____ Date: _____

* Indicates information required for compliant billing