

WORKERS COMPENSATION INFORMATION SHEET

PATIENT'S NAME: _____

PATIENTS D.O.B : ____ / ____ / _____

EMPLOYER'S NAME: _____

ADDRESS: _____

EMPLOYER'S# (____) _____ - _____ **CONT: PERSON:** _____
WORKERS COMPENSATION INSURANCE CARRIER

NAME: _____

ADDRESS: _____

CONTACT PERSON: _____

WORKERS COMP#(____) _____ - _____ **EXT:** _____

DATE OF INJURY : ____ / ____ / _____ **CLAIM#** _____

HAS INJURY BEEN REPORTED TO YOUR EMPLOYER: ____ **YES** / ____ **NO**

HAS THIS PROCEDURE BEEN REPORTED AUTHORIZED: ____ **YES** / ____ **NO**

OPEN CLAIM: ____ **YES** / ____ **NO**

FOR OUR RECORDS PLEASE PROVIDE HEALTH INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____

ID# _____ **GROUP#** _____

ACTIVE AS OF _____ **AUTH#** _____

**FALLURE TO NOTIFY YOUR WORKERS COMPENSATION INSURANCE OF THIS PROCEDURE
MAY RESULT IN DENIAL OF PAYMENT**

**I UNDERSTAND THAT I AM ACCEPTING SERVICES AT VERMONT RADIOLOGIST AND ANY
CHARGES NOT COVERED BY THE ABOVE BILLING AGENTS WILL BE MY
RESPONSIBILLITY**

SIGNATURE: _____ **DATE:** ____ / ____ / _____