Workers Compensation Form

Patient Name:_____Date of Birth:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Employer:_____

Employer Address:_____

Employer City:_____ State:_____ Zip:_____

Employer Phone Number:_____

Workers Compensation Insurance:_____

Insurance Address:_____

Insurance City:_____ State:_____ Zip:_____

Insurance Claim: _____Adjuster:_____Phone:_____

Has first report of injury been filed? [] Yes [] No Date of Injury:_____

Please describe
injury:_____

_____

Health Insurance: _____

Health Insurance Policy Number:_____

I hereby authorize the assignment of benefits (payments) directly to Bonnie M. Abel Bolash, M.Ac., L.Ac. or legal representative for all my insurance claims related to services received for my workers compensation claim. I also agree that if workers compensation denies charges the charges will be billed to my health insurance for reimbursement. I agree to pay any and all charges that exceed, or are not covered by my health insurance.
I also give permission to release any medical records related to the service dates submitted or other records requested to substantiate the claim for reimbursement. In the event that services that were covered were then at a later date determined to not be a covered service I agree to pay for those services rendered

Patient Name:_____DOB: ____/____/____

Social Security:_____

Signature of Responsible Party: _____ Date: ____/____/____