Workers' Compensation Information

If you are being seen for work related injuries, you must provide the following information, which should have been given to you by your employer. We need the correct billing information in order to submit your claim to the responsible party. If you do not know the details, you will need to contact your employer.
If you do not have the information at the time of your appointment, we will be unable to bill your claim. Unless you provide us with the information below, you will be responsible for the full charges after today's visit and that may impact the ability to schedule future appointments.

Patient Name: ____________________

Patient birthdate: ____________ **Social Security Number:** ____________

Employer name: ____________________

Employer address: ____________________

Employer phone number: ____________ **Employer fax number:** ____________

Date of injury: ________ **Injury being seen for:** ____________

Whom should we contact at your place of employment? ____________

Carrier name: ____________________

Carrier address: ____________________

Carrier phone number: ____________ **Carrier fax number**: ____________

Carrier claim number: ____________________

Whom should we contact at the workers' compensation carrier? ____________

Have you been under the care of any other physician for this injury? _____ Yes _____ No

If yes, please provide the physician name: ____________________

To your knowledge, is this claim in dispute, or are there any problems with this claim? _____ Yes _____ No

If yes, please explain: ____________________

Do you have an attorney involved? ____ Yes ____ No

If yes, please provide attorney's name and phone number:

Name ____________________

Phone number ____________________

NOTE: If this claim is disputed or rejected by workers' compensation, you will be responsible for all charges. In order to submit a claim for you, we must have your authorization to release medical information to your employer and or/workers' compensation carrier.

I herby authorize release of information necessary to file a claim for payment of my bills under workers' compensation:

Signature ______________________________ **Date** ____________________

Language assistance available

Español | 繁體中文 | العربية | Assyrian | Tiếng Viêt | Shqip | 한국어 | বাংলা | Polski | Deutsch | Italiano | 日本語 | Русский | Srpsko-hrvatski | Tagalog

370 N 120th Ave Holland MI 49424 phone 616 396 5855 fax 877 592 0688 www.shorelineortho.com