

**ORTHOPAEDIC BONE & JOINT SPECIALISTS, P.A.**

**WORKER'S COMPENSATION  
&  
THIRD PARTY INFORMATION**

ACCOUNT #: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

CLAIM #: \_\_\_\_\_ TYPE OF INJURY: \_\_\_\_\_

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**COVERAGE VERIFICATION**

INSURANCE COMPANY NAME: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Contact Person: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Verified By: \_\_\_\_\_

Medical Records updates to be sent to:

1) \_\_\_\_\_ Address: \_\_\_\_\_

2) \_\_\_\_\_ Address: \_\_\_\_\_

3) \_\_\_\_\_ Address: \_\_\_\_\_

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**PATIENT AUTHORIZATION TO BILL THIRD PARTY OR WORKER'S  
COMPENSATION**

I am instructing Orthopaedic Bone & Joint Specialists not to bill my primary insurance company  
\_\_\_\_\_ for services connected with my accident/injury which  
occurred on \_\_\_\_\_.

I understand that I will remain financially responsible for all charges incurred.

PATIENT'S SIGNATURE: \_\_\_\_\_