ORTHOPAEDIC BONE & JOINT SPECIALISTS, PA

WORKER'S COMPENSATION & THIRD PARTY INFORMATION

PATIENT'S NAME:_____ DOB:_____

SOCIAL SECURITY #:_____ DATE OF INJURY:_____

CLAIM #:_____ TYPE OF INJURY:_____

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COVERAGE VERIFICATION

INSURANCE COMPANY NAME:_____

Address: _____

_____

Name of Employer: _____

Claims Adjuster/Contact Person: _____

Telephone Number:_____Verified By:_____

Date & Time of Verification: _____

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 Health Insurance

Carrier_____

Name of Carrier

for services connected with my accident/injury which occurred on _____

Date

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

PATIENT'S SIGNATURE:_____

Date