ORTHOPAEDIC MULTISPECIALTY NETWORK, INC

Workers Compensation Information Sheet

Name: ____ Date of Birth: __________________

SS#: ________________________ Part (s) of body: _______________________________________

Physician who has treated you for this problem: _________________________ Phone: ________________

Date of Injury: _________________ Employer at the time of injury: ____________________________

Employers Address: ____ Phone: ________________

Job Description and Duties: ____

____Length of Employment:___________

Have you completed the BWC's "FIRST REPORT OF INJURY" form that is required by the Bureau to start your claim?   Yes____   No____ *(If you are unsure, please ask to speak with a Workers' Compensation Specialist)*

Have you missed work due to this injury?   Yes____   No____   First date missed:_____________

Are you still off work?   Yes____   No____   What date did you return to work:______________

Please be advised that even if you were injured on the job, you are still responsible for any charges you incur. You will receive a monthly statement until you advise us of your claim number. Please call our Workers' Compensation department when you receive your claim number. Related charges will then be submitted to Workers' Compensation for payment.

Your health insurance information is required in the event Worker's Compensation denies your claim. It is the policy of this office to confirm your claims status at sixty (60) days. If Workers' Compensation has classified your claim in a "No Pay" status, we will forward a copy of your charges to your health insurance carrier. If no health insurance information is available, we will contact you to arrange a monthly payment plan.

If your health insurance requires a referral for treatment, you must contact your primary care physician to arrange for authorization. **(Failure to do so could result in denial by your health insurance carrier)**

Please check one of the following:

- ❑ I will provide a copy of my health insurance information and understand that I am required to follow any policy guidelines set forth by my insurance carrier.

- ❑ I choose not to provide a copy of my health insurance information and understand that I will become fully responsible for my balance should Workers' Compensation deny my claim or any treatment not allowed in my claim.

- ❑ I do not have health insurance and will accept financial responsibility if Workers' Compensation denies my claim or any treatment not allowed in my claim.

Signature: ____ Date: _______________________

WC Information form
Revised 1/29/08