orthopaedicseast
& SPORTS MEDICINE CENTER

Worker's Compensation Information

Patient Name:	Provider:
Patient Address:	Date of Birth:
Patient Phone Number:	Patient Email:
Date of Injury:	Injured Body Part(s) Approved to Treat:
Employer Company Name:	Employer Address:
Worker's Compensation Carrier:	Worker's Compensation Claim Number:
Carrier Billing Address	
Adjuster:	Adjuster Phone Number:
Adjuster Email:	Adjuster Fax:
Case Manager:	Case Manager Phone Number:
Case Manager Email:	Case Manager Fax:

I understand that per North Carolina State Law (Worker's Compensation Law, 97-27), Orthopaedics East & Sports Medicine Center reserves the right to send all medical information concerning my illness and treatment pertaining to the injury sustained on the job to the Worker's Compensation insurance carrier and/or my employer. I understand the risk involved in faxing medical information.

DENIAL OF WORKER'S COMPENSATION

I understand that verification of my injury DOES NOT guarantee payment of my medical bill. I understand that if my employer and/or insurance company denies a claim, a copy of the denial letter shall be sent by my employer or self-insurer/insurance company to the Industrial Commission, employer, and all known medical providers as soon as an investigation is completed. Once medical providers receive a copy of the denial letter, they may bill my private health insurance or myself as dictated by state law. If I request a hearing, the provider will discontinue billing to myself until after a hearing is held and a final decision is made. However, billing to the private health insurance may continue.

Patient Signature **Date**