



Worker's Compensation Information

Date Of Request:		
Patient Name:	Date of Birth	
Patient Address:	Patient E-mail:	
Patient Phone Number:	Injured Body Part(s) Approved to Treat:	
Employer Company Name:		
Employer Address:		
State of Injury:	Date of Injury:	
Worker's Compensation Carrier:	Worker's Compensation Claim Number:	
Payer ID #:		
Carrier Billing Address:		
Adjuster:	Adjuster Phone Number:	
Adjuster Email:	Adjuster Fax Number:	
Case Manager:	Case Manager Phone Number:	
Case Manager Email:	Case Manager Fax Number:	
Patient Allowed to Schedule/Reschedule Appointments: YES NO		

I understand that per North Carolina State Law (Worker's Compensation Law, 97-27), Orthopaedics East and 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 to 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's Signature

Date