



excellence in brain, spine and pain care

**neurosciencegroup**

**WORKERS' COMPENSATION CLAIM  
ACCIDENT CLAIM**

Please complete all information in the box, then complete the appropriate section for either a **Workers' Compensation Claim** or an **Accident Claim**.

Patient name: _____	Date of birth: _____
Health insurance name: _____	
Health insurance address & phone: _____	
Identification #: _____	Group #: _____

**Workers' Compensation Claim**

*IMPORTANT:*

- Please contact your employer for this information **before** your appointment to avoid receiving a billing statement.
- If you belong to an HMO, you should obtain a referral from your primary care physician. If Workers' Compensation denies this claim, your HMO will not pay unless you had a referral.

Employer: \_\_\_\_\_

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

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of injury: \_\_\_\_\_ Was this injury reported? If so, to whom? \_\_\_\_\_

Send claim to my employer  Send claim to Worker's Compensation Insurance at:

Company name: \_\_\_\_\_

Address (PO Box, if possible): \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Claim #: \_\_\_\_\_

**Accident Claim**

Type of accident: \_\_\_\_\_

Date of accident: \_\_\_\_\_ State where accident occurred: \_\_\_\_\_

Party at fault: \_\_\_\_\_ Name of policy holder: \_\_\_\_\_

Send claim to the following insurance carrier: [Is this your policy? Yes No]

Company name: \_\_\_\_\_

Address (PO Box, if possible): \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Claim #: \_\_\_\_\_

**I UNDERSTAND THAT IF THE WORKERS' COMPENSATION CARRIER, EMPLOYER, ACCIDENT CARRIER, AND/OR HEALTH INSURANCE CARRIER DO NOT PAY THIS CLAIM, I AM RESPONSIBLE FOR PAYMENT OF THIS CLAIM.**