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.