POLIN NEUROSURGERY

WORKERS COMPENSATION INFORMATION

Date:_____

In order for our office to file your Worker's Compensation claim, please completely fill out the following information:

Patient Name: _____DOB: _____

Primary Care/Attending Physician: _____ Phone: _____

Claim#: _____

Is the claim enrolled in a managed care organization? If so, who?_____

Date of Injury (DOI): _____

Attorney Name:_____ Phone: (_____)_____ Fax: (_____)_____

Adjustor's Name: _____ Phone#: (_____)_____Fax: (_____)_____

Employer's Name: _____

Worker's Comp Carrier: _____

Address (Claims):_____

_____

City State Zip

If in the event your claim is **denied or deferred** by your worker's compensation insurance, it is our policy to file your claims to your private health insurance.

Please note, in filing to your private health insurance, this is not a guarantee of payment, your private health insurance may pend your claim until completion of your worker's comp appeals process.

It is important that you contact our office in the event of a denial to let us know if there is an appeal in process. This will be required for each denial that may take place.

If you have any questions please ask to speak to our billing department. Thank you.

_____

Signature Date

*Your signature indicates you have read and understand our policy

PLEASE BRING A COPY OF THE ACCEPTANCE LETTER FROM YOUR ADJUSTOR TO YOUR FIRST VISIT