



P.O. Box 100108 • Staten Island, New York • 10310-0108 • (718) 447-4900 • Fax (718) 447-4511

WORKER'S COMPENSATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **APT #** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMPLOYER'S NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

COMPENSATION CARRIER NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CARRIER CASE / CLAIM # _____

In many instances, Workman's Compensation claims are delayed or rejected due to incomplete information. Please be sure you have completed the above questions accurately and legible in order to expedite payment of this claim.

The responsible party in a Worker's Compensation case is the insurance carrier for the employer. However, the patient is ultimately the responsible party in the event the claim is not accepted by the employer's carrier as a Worker's Compensation related injury.

I hereby authorize Regional Radiology to furnish information to my insurance carrier concerning this illness/accident, and I hereby irrevocably assign payment to Regional Radiology for medical services rendered to me.

SIGNATURE: _____ **DATE:** _____