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Auburn, New York 13021-2663
t 315.253.3291
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WORKERS' COMPENSATION INSURANCE FORM

The following information is required for billing the worker's compensation carrier for your physical therapy

Patient Name: ______________________ Date: ______________________
Patient Address: ______________________
Diagnosis: ______________________
Date of Birth: ______________________ SS#: ______________________
Phone (home) ______________________ Phone (work) ______________________

Employers' Name and Address ______________________
*Workers" Compensation Carrier ______________________ *Phone #: ______________________
*Carrier Address ______________________
Carrier Case # (if known) ______________________
Case Worker ______________________ Case Worker Phone ______________________
WBC#: ______________________
* Your employer must provide this information for you and submit their report within 30 days of the accident

Referring Physician: ______________________
Physician Address: ______________________
Physician Phone: ______________________
Date of Accident: ______________________
Location of Accident: ______________________
Lost Time from Work? Yes No (circle one)

Are you seeing a chiropractor Yes No (circle one)

I certify that:

1. I have reported this injury to my employer
2. My employer has sent the report to the insurance company **, and
3. The referring physician has determined this is a work related injury and is billing the workers' compensation carrier.

** Physical therapy requires an authorization from the insurance carrier. If they have not received a report from the employer and a report from the physician, we will not be able to obtain authorization for therapy services.

I understand I am not allowed to see a chiropractor for this injury during my authorization period for physical therapy.

In the event the claim is controverted (disputed) by the workers' compensation carrier, and the court decides in the carrier's favor, I understand I am responsible for payment of my physical therapy services rendered. I will provide the necessary private health insurance information so that my private insurance carrier can reimburse COAST Physical Therapy or I agree to make payment directly.

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Signature Date