JAMES M. LEIPZIG, M.D., F.A.C.S.
SPINAL SURGERY

Worker's Compensation Verification

Name____

Phone ________________________

Address____

City_____________________State_________________Zip______________

Date of Injury________________________ Claim Number________________

Nature of Injury____

Employer Supervisor/Contact Name__________________________________

Employer Address______________________________________

Employer Phone____

City _______________________State_______________ Zip_______________

Compensation Carrier_______________________ Contact Name____________

Claims Address________________________________ Phone________________

City________________________State_______________ Zip_______________

*** Once receiving this information, please contact your carrier/adjustor to obtain approval of your office visit. If your visit is not approved, you will be responsible for payment.**

Authorization

I certify that the information given by me in regard to worker's compensation is correct. To the best of my knowledge, the claim is active at the time of this signature. I also understand that I may be responsible for payment of services not covered by the Bureau of Worker's Compensation program. I hereby give my permission for my charges to be submitted to my private medical insurance carrier if this worker's compensation claim is denied or found to be invalid.

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(Signature) (Date)