CFM
Compassionate Family Medicine

WORKERS' COMPENSATION INFORMATION REQUEST

Please make sure that you report the injury to your Employer so that you are able to provide the following information. All medical bills must be submitted to the Insurance carrier in a timely manner. If this cannot be done due to the lack of insurance information, you may be held responsible for the balance due. Thank you for your cooperation.

This form must be ENTIRELY completed in order for us to file your claim to your worker's compensation carrier.

Patient Name: _____
(First, Middle, Last)

Patient's Date of Birth: _____ **Patient's Social Security Number**: _____
(month / day / year)

Patient's Address: _____
(Street, City, State, Zip Code)

Patient's Phone Number: **(Home)** _____ **(Cell)** _____

Patient's Employer: _____

Employer's Address: _____
(Street, City, State, Zip Code)

Employer's Phone Number: _____

Worker's Compensation Insurance Company Name: _____

Insurance Company Address: _____
(Street, City, State, Zip Code)

Contact / Insurance Adjuster's Name: _____

Adjuster's Direct Telephone Number: _____ **Fax**: _____

Compensation Claim Number: _____ **Date of Injury**: _____

Brief Description of how your injury occurred: _____

_____

_____

Body Part(s) Injured (Be Specific): _____

_____

_____

Were you under the care of another physician, hospital, or medical center for this injury?

[ ] Yes [ ] No If yes, please state where: _____

_____

_____

311 Green Street
Syracuse, NY 13203
T: (315) 425-1431
F: (315) 425-1994

511 South Main Street
North Syracuse, NY 13212
T: (315) 425-1431
F: (315) 452-9607

138 East Genesee Street
Baldwinsville, NY 13027
T: (315) 425-1431
F: (315) 638-1445

2700 Court Street – 2nd Floor
Syracuse, NY 13208
T: (315) 425-1431
F: (315) 455-6873

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WORKER'S COMPENSATION WAIVER

CONSENT TO TREAT

Patient Name *(please print)*: _____
First Name *Middle* *Last Name*

Date of Birth: _____ / _____ / _____
Month *Day* *Year*

Insurance Carrier Name: _____

Claim Number: _____

Date of Injury: _____ / _____ / _____
Month *Day* *Year*

I, _____, am aware that the insurance carrier may require me to be treated by an Independent Medical Examiner (IME) designated by the insurance company. If I fail to attend the IME appointment, the insurance carrier may deny my doctor visits with CFM. Therefore, I will be responsible for any unpaid visit(s).

Patient Signature: _____

Date: _____ / _____ / _____
Month *Day* *Year*

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