Worker's Compensation Form

Inspired Health Group

3671 Southwestern Blvd. Suite 101, 110 & 213

Orchard Park, NY 14127

Name: _____

Address:_____

Date of Injury:_____

Type of Injury:_____

How did Injury Occur?

_____

_____

Place of Employment:_____

Address:_____

Phone:_____

Insurance Carrier for Employer:_____

Address:_____

Phone: _____

WCB#: _____

Inspired Health Group

Carrier Case #:_____

Work Status: Working:_____ **Not Working:**_____

If not working, what date did you stop working?_____

In order to bill Worker's Compensation, all information above must be filled out by the employee. Failure to do so may result in delay in claims processing and/or patient responsibility of payment.

I request that payment of authorized Worker's Compensation benefits be made to Inspired Health Group. I also authorize Inspired Health Group to release any medical information to the insurance carrier for the sole purpose of processing claims and/or determining benefits.

Print Name:_____ **Date:**_____

Signature of patient or Responsible Party:_____ **Date:** _____

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