



Moving you to wellness.

WORKER'S COMP

MIDWEST PHYSICAL THERAPY AND SPORTS CENTER

BILLING INFORMATION

Please print clearly. To insure that the proper parties are billed- please answer the following questions and sign. Thank you!

Patient's name: _____

Student: No [] / Yes - School name: _____ Full [] Part time []

Do you have Medicare coverage? Y / N Do you have an attorney working on your case? Y / N (IF YOU ANSWERED 'YES' TO EITHER OF THE ABOVE QUESTIONS, PLEASE INFORM THE RECEPTIONIST)

Date of injury: ____ / ____ / ____ OR When did you first notice symptoms? ____ / ____ / ____

Employer Name: _____ Phone (____) _____

Address: _____

Contact (personnel dept): _____ Fax (____) _____

Claim #: _____

Is your injury claim approved [] or is it being contested [] by your employer?

Your employer's W/C insurance carrier: _____

Address: _____

Contact and/or Adjuster: _____ Phone (____) _____

Case Manager: _____ Phone (____) _____

Fax (____) _____ Email: _____

Address: _____

Is prior authorization required for physical therapy Yes [] No [] Unknown []

PLEASE NOTE:

In the event your claims are denied, you will become financially responsible for the full amount. As a courtesy, we ask for health insurance information as back-up from all our workers' compensation patients. Claims are sent to your employer's W/C insurance, not to your employer. Please have your employer contact us if they have requested that claims be sent to them. We can provide copies upon request.

Health insurance card copied [] Insurance name: _____

Patient/Guarantor Signature: _____ Date: ____ / ____ / ____