A P M I
Advanced Pain Medicine Institute
Reza Ghorbani, MD, ABIPP, FIPP
President and Medical Director

YOU WERE INVOLVED IN A WORK COMPENSATION ACCIDENT

What we need from you:

- Date of accident
- Name of WC covering this claim
- Claim number
- Claim adjuster name and phone number

What you need to know:

- Your health insurance policy will not pay your work compensation invoices except if you have denial from your work compensation case.

Attorney:

- You have an attorney who is representing you in the case please sign an A/A that gives him/her access to your file and make him/her responsible of your bills on your behalf (page 1).

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WORK COMPENSATION ACCIDENT

Name of Patient: _____

DOB: _____/_____/_____

If you have been involved in a work compensation accident and today's visit is related to injuries you sustained during this accident, we will need some information from you to bill correctly as possible.

What is your work compensation insurance name? _____

Claim Number: _____

Phone Number: (_____)_____-_____ Date of accident: _____/_____/_____

Adjuster name: _____

Name of Attorney: _____

Phone Number: (_____)_____-_____

A/A signed: _____

Authorization for visit done on: _____/_____/_____

Conditions authorized on the case: _____

Signature: _____ Date: _____/_____/_____