Workers Compensation Injuries

Assignment of Benefits

Patient name: _____ **Date of birth:** _____

Insurance Information

Worker's compensation carrier information

Name of carrier						
Street						
City			State	Zip		
Carrier phone number	Carrier fax number		Case number		WCB#	
Case manager's name			Case manager phone number		Case manager fax number	

Employer

Name		Phone number
Contact person		
Street		
City	State	Zip code

Injury information

Date of injury	Body part(s) injured
Location of injury	

I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical and/or surgical benefits, including major medical benefits to which I am entitled, by Upper East Orthopaedics. This agreement will remain in effect until revoked by me in writing. A photocopy of this release and assignment is to be considered as valid as the original.

I hereby authorize payment of benefits under the Accident/injury plan to be paid directly to Upper East Orthopaedics for services rendered to me as the result of an accident/injury which occurred. If for any reason my Insurance Carrier rejects this claim, I am responsible for the charges incurred. I therefore agree to pay Upper East Orthopaedics their usual and customary fees for services rendered by Upper East Orthopaedics to me.

X _____ _____

Signature Date