Amherst Physical Therapy

282 Route 101 Unit 11, Amherst, NH 03031

Worker's Compensation Information

Patient Name: _____

You have indicated to us that we are billing workers compensation or your personal injury insurance. We need specific information to bill on your behalf. If you feel you have already provided us with the necessary information, we ask that you verify that this information is correct. If you have not provided us with this information, please fill in the information below.

Claim Number: _____

Date and State of Injury: _____

Employer: _____

Who referred you to us? _____

W/C Insurance Company: _____

Case Manager Name: _____ Phone: _____

Billing Address: _____

_____

Health Insurance Information:

Primary Insurance:		Insurance Identification Number:	
Policy Holder Name:	**Is policy holder a <u>RETIRED</u> Federal Employee?** ☐ **Yes** ☐ **No**	Sex: ☐ M ☐ F	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Other
Policy Holder Date of Birth:	Policy Holder SSN	Policy Holder Address:	

When worker's compensation benefits are exhausted or denied, we will bill your personal health insurance

****If we do not have the correct information, this is a reminder that you will****
****be held responsible for the total amount of the charges.****

I have read the above statement and understand my financial responsibilities.

_____ _____

Signature Date