Elite Rehab and Sports Therapy

Worker's Compensation/Auto Accident Information

Patient Name: ____

You have indicated to us that we are billing workers compensation, auto insurance 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 this with one of our staff. If you have not provided us with this information, please fill in the information below.

Claim Number: ____

Date and State of Injury: ____

Employer (W/C only): ____

Who referred you to us? ____

W/C or Auto Insurance Company: __________________________________

Case Manager Name: _____________________ **Phone:** _______________

Billing Address: ____

____

Health Insurance Company: ______________________________________

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

Patient has already provided us with the necessary info:__________
Staff Initials

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**