North Fork Radiology, P.C.

1333 Roanoke Avenue ● Riverhead, NY 11901 ● 631-727-2755

Worker's Compensation – No Fault Information

Name:____________________________________ DOB___________________SS#______________________

Address___________________________City_______________State_____Zip________Ph#________________

Employer______________________________Employer Ph#________________Contact person____________

Job Injury?________ Auto Accident Injury?________ Date of Injury?______________________________

Name of Insured ______________________________Insurance Carrier_____________________________

Ins Address________________________City_____________State_____Zip________Ph#________________

Claim #____________________________Policy #__________________________WCB#__________________

Attorney Name & Address:____

Briefly state how the accident occurred.

____

____

Type of radiology exam: _________________________________Referring physician____________________

In the event that I fail to procure a claim for Worker's Compensation/No Fault for this injury or it is determined that the condition is not a result of the above accident or deemed not medically necessary, I hereby agree to pay North Fork Radiology, P.C. the usual and customary fees for services rendered. I understand it is my responsibility to provide to this office the insurance information necessary to process this claim and hereby agree to be responsible for any fees if I fail to provide said information.

Patient Signature____Date___________________

In the event my Worker's Compensation/No Fault does not pay for the services rendered, I understand that my <u>private health insurance</u> may cover these services. I authorize North Fork Radiology, P.C. to file a claim with my <u>private health insurance</u>.

Insurance Carrier: ____ Ph#___________________________

Address____________________________________City____________________State________Zip___________

Policy/ID #: ______________________________ Policy holder:____________________ DOB:_____________

Patient Signature: ____ Date___________________

Office Use Only

Authorization#________________________________ LOMN___________ LOA ____________ Ins card____