Coast PT
Cayuga Orthopaedic and Sports Physical Therapy

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WORKERS' COMPENSATION INSURANCE FORM

The following information is required for billing the worker's compensation carrier for your physical therapy

Patient Name: _____ Date: _____
Patient Address: _____
Diagnosis: _____
Date of Birth: _____ SS#: _____
Phone (home) _____ Phone (work) _____

Employers' Name and Address _____
*Workers" Compensation Carrier _____ *Phone #: _____
*Carrier Address _____
Carrier Case # (if known) _____
Case Worker _____ Case Worker Phone _____
WBC#: _____
* Your employer must provide this information for you and submit their report within 30 days of the accident

Referring Physician: _____
Physician Address: _____
Physician Phone: _____
Date of Accident: _____
Location of Accident: _____
Lost Time from Work? Yes No (circle one)

Are you seeing a chiropractor Yes No (circle one)

I certify that:

1. I have reported this injury to my employer
2. My employer has sent the report to the insurance company **, and
3. The referring physician has determined this is a work related injury and is billing the workers' compensation carrier.

** Physical therapy requires an authorization from the insurance carrier. If they have not received a report from the employer and a report from the physician, we will not be able to obtain authorization for therapy services.

I understand I am not allowed to see a chiropractor for this injury during my authorization period for physical therapy.

In the event the claim is controverted (disputed) by the workers' compensation carrier, and the court decides in the carrier's favor, I understand I am responsible for payment of my physical therapy services rendered. I will provide the necessary private health insurance information so that my private insurance carrier can reimburse COAST Physical Therapy or I agree to make payment directly.

Signature Date