

# WOODFIELD ORTHOPAEDICS & SPORTS MEDICINE, LTD

1102 S. Roselle Rd.  
Schaumburg, IL 60193  
847/301-7773 Fax 847/301-6506

## WORKER'S COMPENSATION VERIFICATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

### **Employment Information** (at the time of injury):

Employer \_\_\_\_\_  
Contact \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Description of Injury \_\_\_\_\_  
Date of Injury \_\_\_\_\_

### **Bill to Worker's Compensation Insurance Company**

Address \_\_\_\_\_ Claim# \_\_\_\_\_

**Adjustor** \_\_\_\_\_  
Email address \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_

**Nurse Case Manager** \_\_\_\_\_  
Email address \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_

### **Authorizations:**

I hereby authorize Woodfield Orthopaedics & Sports Medicine, Ltd. (WOSM) to release information obtained during the course of my examination and treatment to my authorized worker's compensation insurance carrier for the above described injury. I hereby assign payment directly to WOSM for any medical services rendered. I understand that I am responsible for payments for all services rendered and associated costs for collection should such action become necessary if worker's compensation coverage is denied for any reason. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof:

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize WOSM to release information to anyone requesting information in regard to my worker's compensation claim over the telephone and identifying themselves as a representative of my worker's compensation carrier:

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

I certify that the information given by me in regard to worker's compensation is correct. To the best of my knowledge, the claim is active at the time of this signature. I also understand that I may be responsible for the payment of services not covered by the Bureau of Worker's Compensation program. I hereby give permission for my charges to be submitted to my private health insurance carrier if this worker's compensation claim is denied or found to be invalid.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_