montgomery medical associates, pc

Worker's Compensation Form

First Name: ..... Last Name: .....

Date of Birth: .....

Date of Incident: ..... State of Incident: .....

Claim Number: .....

Insurance Carrier Name: .....

Claim Adjuster Name: .....

Claim Adjuster Phone Number: ..... Ext: .....

Insurance Carrier Phone Number: .....

Insurance Carrier Claim Address: .....

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Employer: .....

Employer Contact Name: .....

Employer Contact Phone Number: ..... Ext: .....

Employer Address: .....

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Do Services Require Authorization? ☐ Yes ☐ No

Attorney Name: .....

Attorney Phone Number: ..... Ext: .....

Attorney Address: .....

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I hereby authorize Montgomery Medical Associates, P.C. the release of any medical information necessary to process a claim. I hereby assign payment directly to Montgomery Medical Associates, P.C. all payments due from my insurance company and or attorney. I understand that I am financially responsible for the charges are the responsibility of the patient.

Patient Signature: ..... Date: .....