Carolina Sports and Spine

(Administration Only)
Today's Date:
Initials:
Patient #:
Date of Appt:
Time:
Location:
Provider:

Worker's Compensation Information

Patient Name	**Date of Birth**
Patient Address	
Patient Phone#	
Social Security#	**Date of Injury/Injured Body Part**
Employer	**Contact**
Address	**Phone#**
Where has patient been treated?	**Have X-Rays been done?** ☐ Yes ☐ No
Case Manager	**Phone#**
Email Address	**Fax #**
Comp Carrier	**WC Claim#**
Address	
Adjuster	**Email Address**
Phone#	**Fax #**

I understand that per NC state law (Worker's Compensation Law, 97-27), Carolina Sports and Spine, PA reserves the right to send all medical information concerning my illness and treatment pertaining to the injury sustained on the job to the Worker's Compensation insurance carrier and/or my employer. I understand the risk involved in faxing medical information.

DENIAL OF WORKER'S COMPENSATION

I understand that verification of my injury DOES NOT guarantee payment of my medical bill. I understand that if my employer and/or insurance company denies a claim, a copy of the denial letter shall be sent by my employer or self-insurer/insurance company to the Industrial Commission, employer, and all known medical providers as soon as an investigation is completed. Once medical providers receive a copy of the denial letter, they may bill my private health insurance or myself as dictated by state law. If I request a hearing, the provider will discontinue billing to myself until after a hearing is held and a final decision is made. However, billing to the private health insurance may continue.

Patient's Signature _____**Date**_____