



HIGH MOUNTAIN HEALTH, P.A. Worker's Compensation Claim Form

Please complete the form in its entirety. Failure to do so will result in the bill becoming the patient's responsibility until all of the information is received. Our staff will gladly assist you in any areas you do not understand. Thank you for your cooperation.

Please check one: Auto Accident Worker's Compensation

Patient Information

Patient's Name: _____

Patient's Date of Birth: _____

Home Phone: _____ Work Phone: _____

Insurance Information

Date of Accident: _____ Time of Accident: _____

Insurance Company Name: _____

Insurance Company Phone Number: _____

Insurance Company Billing Address: _____

City: _____ State: _____ Zip: _____

Claim Number: _____

Adjuster's First and Last Name: _____

Adjuster's Phone Number: _____

Is there an existing open file: Yes No

Auto Accident

Have you submitted the police report to your insurance company? Yes No

Have you completed your PIP application? Yes No

Worker's Compensation

Your Occupation: _____

Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Phone Number: _____

Contact Name: (First and Last name): _____

Patient/Guardian Signature: _____ Date: _____

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