WORKERS COMPENSATION INFORMATION 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.

Patient Name: ____ D.O.B: ____________

Home Phone: ______________________________ Work Phone: ______________________

Employer Name: ____________________________ Occupation: ______________________

Employer Address: ____

Employer City: __________________________ State: ______________ Zip: ______________

Employer Phone #: ____

Contact Name (First and Last): ____

Workman's Compensation Carrier: ____

Workman's Compensation Carrier Address: ___________________________________

Workman's Compensation Phone #: ____

Insurance Authorization # for treatment: _____________________________________

Claim #: ____

Date of Accident: __________________________ Time of Accident: _________________

Date Authorization Obtained: ________________ State the accident took place: ________________

I ______________________ agree to pay for services provided at High Mountain Health if payment is denied for any reason.

Patient/Guardian Signature: ____________________________________ Date: ____________

Wayne – Urgent Care
246 Hamburg Tpk
Ph: 973.389.1800
Fax: 973.636.2734

Wayne
468 Parish Drive
Ph: 973.305.8300
Fax: 973.305.8157

Waldwick – Urgent Care
71 Crescent Ave
Ph: 201.445.1700
Fax: 201.445.1701

Billing Department
401 Hamburg Tnk
Ph: 973.890.2780
Fax: 973.890.8960

Like us on Facebook
High Mountain Medical Group

Visit our website at:
www.HighmountainHealth.com