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Middleton
FAMILY MEDICINE
URGENT CARE

Workers Compensation Insurance (WC)

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

Date of Incident: _____

Body Part(s) Injured: _____

WC Insurance: _____

WC Claim Address: _____

_____

Claim Number: _____

Adjustor: _____Adjustor Phone _____

If you are the subscriber list as self
Health Insurance: _____ Subscriber: _____
Relationship: _____ Subscriber DOB: _____
Member ID: _____Group No.: _____

Please read
I authorize the assignment of all medical payments from all insurance(s) listed above for office visits/procedures related to this accident/injury sent directly to Middleton Family Medicine Urgent Care. In the event that WC insurance does not approve claims I assume full responsible for all payments. If I have Medical Health insurance it is my responsibility to inform the billing department at Middleton Family Medicine within 90 days of the date of service that is denied along with any letters from WC stating why they are denying the claim. If both parties deny a claim it is my responsibility to resolve this matter by contacting them. I become financially responsible for all balances due.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____