DATE COMPLETED: ______________________

ORTHOTIC AND PROSTHETIC SPECIALTIES

Patient Name: _______________________________
Date of Birth: ________________________________

WORKER'S COMPENSATION INFORMATION:

Date Of Injury:___________________

EMPLOYER INFORMATION:

Employer:____

Address:____

____

Telephone #:____

WORKER'S COMPENSATION INFORMATION:

W/C Insurance Company:____

Address:____

____

Telephone #:____

W/C Claim #:____

Contact Person at Insurance Co.:____________________________________

WE FILE INSURANCE AS A COURTESY TO THE PATIENT. THE OFFICE WILL WAIT 60 DAYS TO HEAR FROM INSURANCE AFTER A CLAIM IS FILED. AFTER THE 60 DAY WAITING PERIOD, THE PATIENT WILL BE RESPONSIBLE AND MAY BE REIMBURSED BY THE INSURANCE COMPANY.

IT IS ALWAYS THE PATIENT'S RESPONSIBILITY TO BE SURE WE ARE GIVEN COMPLETE BILLING INFORMATION. FAILURE TO DO SO WILL RESULT IN THE PATIENT BEING RESPONSBILE FOR ANY BALANCE INCURRED.