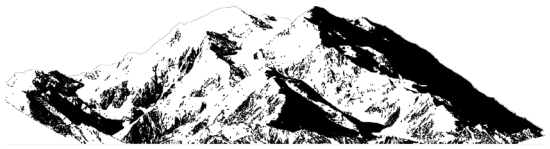


McKinley
Orthopedic & Sports Medicine

WORKMEN'S COMPENSATION INFORMATION

Patient's Name: _____ Date: _____

INFORMATION REQUIRED TO BILL WORKMEN'S COMPENSATION CLAIMS:

DATE OF INJURY: _____

Employer at the time of the injury: _____

Workmen's Compensation CARRIER: (this is different from your employer)

_____

Workmen's Compensation CLAIM #: _____

Workmen's Compensation Carrier Address: _____

Workers Comp Ins Contact Person: _____ Phone #: _____

AGREEMENT

The Undersigned hereby agrees to supply McKinley Orthopedic & Sports Medicine with the above (NEEDED) information within 5 days for the medical services provided to the above-named patient.

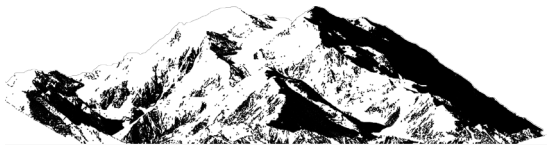
**** IN THE EVENT THE ABOVE INFORMATION IS NOT SUPPLIED TO MCKINLEY ORTHOPEDICS & SPORTS MEDICINE WITHIN THE SPECIFIED TIME (5DAYS) OR THE CLAIM IS DENIED BY CARRIER I UNDERSTAND THAT THE ACCOUNT BALANCE WILL BECOME THE GUARANTOR'S IMMEDIATE RESPONSIBILITY ****

Patient Signature: _____ Date: _____

Received by: _____ Date & Time: _____

BACK SIDE STAFF ONLY

Timothy Carey, DO | Jennifer Malcom, DO | Gary Molk, DO | Kim Driftmier, MD
Tommie Younker, PA-C | Jennifer Holt, PA-C | Shannen McNamara, PA-C | Brianna Graham, NP | Robert Wood, PA
3745 Geist Road, Fairbanks, Ak 99709 | Office: 907.456.3338 | Billing: 907.456.3341 | Fax: 907.456.3443



McKinley
Orthopedic & Sports Medicine

(STAFF ONLY)

WC INFORMATION CONFIRMATION

Please call the WC insurance to confirm the following information:

PATIENT ACCT# _____

SPOKE WITH: _____ PHONE #: _____

BODY PART COVERED: _____

DATE OF INJURY: _____ WC

INSURANCE CARRIER: _____

CLAIM NUMBER: _____

ADJUSTER NAME: _____

ADJUSTER PHONE: _____

CLAIMS MAILING ADDRESS:

_____

_____

Information collected & confirmed by:

X: _____ Date: _____

Timothy Carey, DO | Jennifer Malcom, DO | Gary Molk, DO | Kim Driftmier, MD
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