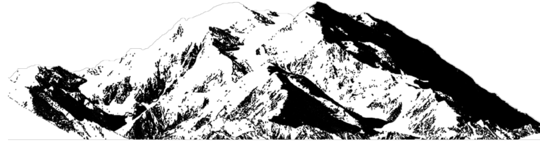


McKinley
Orthopedic & Sports Medicine

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 #: ___________________

Received by: _____________________________________ Date & Time: ________________________________

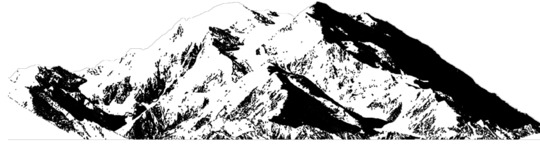
ARGEEMENT

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: ______________________________

**Timothy Carey, DO | Kim Driftmier, MD | Gary I Molk, DO | Jennifer Malcolm, DO**
**Tommie Younker, PA-C | Jennifer Holt, PA-C | Shannen McNamara, PA-C**
3745 Geist Road, Fairbanks, Ak 99709 Office: 907.456.3338 | Fax: 907.456.3443




# (STAFF ONLY)

**WC INFORMATION CONFIRMATION**

Please call the WC insurance to confirm the following information:

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 | Kim Driftmier, MD | Gary I Molk, DO | Jennifer Malcolm, DO**
**Tommie Younker, PA-C | Jennifer Holt, PA-C | Shannen McNamara, PA-C**
3745 Geist Road, Fairbanks, Ak 99709 Office: 907.456.3338 | Fax: 907.456.3443