Knee Center of Western New York **Workers Compensation/No Fault Form**

Please complete if Workers Compensation or Auto accident (No Fault)

If you are unable to provide us with this information, or your claim is not yet in process, you will be responsible for the payment of your office visit until the information is presented to us. Also, we recommend that you have a back - up referral in place with your personal health insurance carrier to help you cover any costs that may be denied by the Workers Compensation, No-fault or third party liability carrier.

Patient Name: **Patient DOB:**

Attorney Name: _____ Address: _____ Phone: _____

Date/Time of accident injury: _____ Adjuster/Case Manager Name: _____

Name of Insurance Carrier: _____ Claim #/Carrier Case# Policy #:_____

Insurance Carrier Address:_____ City: _____State _____ Zip: _____

Insurance Carrier Phone #: _____ Insurance Fax#: _____

If No Fault/Auto Accident: Please complete the attached Assignments of Benefit form.

Please complete the following only if Worker's Compensation:

Employer: _____ Employer phone #: _____

Employer Address: _____City:_____ State: _____ Zip:_____

Location injury occurred (if different from employer address): _____

Job Title and time of injury: _____ Body Part(s) Injured:_____

Date Injury reported to your employer: _____

Description of how injury occurred: _____

_____

Have you lost time from work due to this injury: ☐No ☐Yes If yes: what dates: _____

Have you had the same or similar injury prior to this accident ☐No ☐Yes If yes: what dates:_____

Have you been treated by another doctor for this injury: ☐No ☐Yes If yes: by whom: _____

The information on this form has been completed accurately to the best of my knowledge. I understand it is my responsibility to inform the doctor's office of any change in my information.

X._____

Signature of patient or parent/legal gurardian (if patient is under 18 years of age)