# WORKERS' COMPENSATION CLAIM INFORMATION REQUEST

Orthopedic Associates of Lancaster, LTD.

## Patient Information

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____ Email: _____

Date of Injury: _____

Injured Body Part(s): _____

**** If multiple body parts, list all and include side (left or right)*

## Employer Information

Name: _____

Address: _____

_____

Phone: _____

Case Manager Name: _____

Case Manager Phone: _____ Case Manager Fax: _____

## Insurance Information

Insurance Carrier: _____

Claim Number: _____

Billing Address: _____

_____

Adjuster Name: _____

Adjuster Phone: _____ Adjuster Fax: _____

**If workers' compensation denies the claim, any remaining balances will be billed directly to the guarantor. If this occurs and you want your claim to be sent to personal medical insurance, complete the following section:**

Insurance Company: _____

Member ID: _____ Group ID: _____

Claims Address: _____

*Back of Insurance Card*

_____

Policyholder Name: _____

*Policyholder/Subscriber - the person whose employer provides the policy as a benefit or person paying for the insurance premium*

Patient's relationship to subscriber: **Child** **Self** **Spouse** **Other:** _____

**RETURN THIS FORM WITHIN 10 DAYS OF RECEIPT TO ORTHOPEDIC ASSOCIATES OF LANCASTER**
**FAX: 717-327-2794 EMAIL: OALCLAIMINFO@FIXBONES.COM**