



## WORKERS COMPENSATION INFORMATION FORM

Please complete the form in its entirety. Failure to do so will result in the bill becoming the patient's responsibility until all of the information is received. Our staff will gladly assist you in any areas you do not understand. Thank you for your cooperation.

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_

Contact Name (First and Last): \_\_\_\_\_

Workman's Compensation Carrier: \_\_\_\_\_

Workman's Compensation Phone #: \_\_\_\_\_

Insurance Authorization # for treatment: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Date Authorization Obtained: \_\_\_\_\_ State the accident took place: \_\_\_\_\_

Is there an existing open claim: Yes / No

I \_\_\_\_\_ agree to pay for services provided at High Mountain Health if payment is denied for any reason.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Wayne – Urgent Care**  
246 Hamburg Tpk  
Ph: 973.389.1800  
Fax: 973.636.2734

**Wayne**  
468 Parish Drive  
Ph: 973.305.8300  
Fax: 973.305.8157

**Little Falls - Pediatrics**  
83 Long Hill Rd  
Ph: 973.785.2440  
Fax: 973.785.0141

**Waldwick – Urgent Care**  
71 Crescent Ave  
Ph: 201.445.1700  
Fax: 201.445.1701

**Clifton Urgent & Primary Care**  
721 Clifton Ave. Suite 2A  
Ph: 973.777.7727  
Fax: 973.779.7906



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