Appt Date__________
Account #_________
Physician_________

Midwest Orthopaedic Institute, S.C.

Workers' Compensation Verification

Questions? Call Midwest at 815-758-7481 Fax completed sheet to Midwest at 815-756-7130

--------------------------------------- ***EMPLOYER SECTION*** ---------------------------------------

Name of Employer ____

Address ____

City/State/Zip ____

Contact Person ______________________ Phone Number ______________________

Worker Comp Carrier ____
(Insurance Company)

Billing Address ____

City/State/Zip ____

Contact Person ______________________ Phone Number ______________________

Send Insurance Claim to: ____Carrier (Insurance) _____Employer

Type of Injury ____

____

Date of Injury ______________________ Claim # ______________________

Employer Signature: ______________________ Date ______________________

--------------------------------------- ***EMPLOYEE SECTION*** ---------------------------------------

Worker/Patient Name: ____

Date of Birth ______________________ Social Security Number ______________________

Address ____

City/State/Zip ____

Home Phone ______________________ Work Phone ______________________

Group Health Insurance Company ____

Plan Name/Number ______________________ Group Number ______________________

☐ Health Insurance Card Scanned by Reception Staff

Responsibility for payment: I understand that if my claim is denied by Worker's Compensation, my group health insurance will be billed and I will be fully responsible for the charges for my visit/treatment.

Patient Signature: ______________________________ Date ______________