RICHMOND
Family Medicine

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Richmond, VT 05477
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Worker's Compensation Form

If you do not have this information at the time of your visit, we will provide a copy of this form for you to complete. The form must be returned within one week from the date of service to prevent billing to you or your medical insurance carrier. Please work with your employer/worker's compensation agency to complete the form accurately and return it to a member of our staff.

Patient Information

Name of Claimant: _____ DOB: _____

Social Security #: _____-_____-_____ Home Phone: _____

Home Address: _____

Briefly describe injury: _____

Part of body injury is located: _____ Date of Injury: _____

Employer Information

Employer: _____ Employer Phone: _____

Employer Address: _____

Contact Person: _____ Contact Phone: _____

Is claim open? Yes _____ No _____ Does Carrier have claim? Yes _____ No _____

Workman's Comp Carrier Information

Submit all clams to: _____ Phone: _____

Address: _____

_____

_____

Name of Adjuster: _____ Phone: _____

Date of Injury: _____ Claim/Authorization # : _____

I have submitted all information to the best of my knowledge and what Worker's Compensation does not pay I know that I am held accountable. I do understand that you can submit my claim to my Commercial insurance at a timely notice if denied by Worker's Comp. With this signature I am authorizing Richmond Family Medicine to disclose relevant medical information to my workers comp carrier. AUTHORIZATION FOR MEDICAL INFORMATION: With my signature (or photocopy hereof), I understand I am granting Richmond Family Medicine authorization to furnish all information regarding my injury/condition while under observation or treatment, including all medical, family, and social history obtained, diagnostic studies, and physical findings, diagnosis and prognosis to the aforementioned third-party insurance company. I am aware that this may include disclosures regarding my mental health and substance abuse history. I also understand that if I refuse to sign this release, Richmond Family Medicine will not submit this claim to the third-party insurance company and I will be held personally responsible for all associated charges. I also understand that this form does not guarantee payment; if claims are submitted and denied by the third-party insurance company, I will be held personally responsible for any balance due.

Signature: _____ Date: _____