HIGH MOUNTAIN HEALTH, P.A.
Worker's Compensation Claim 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.

Please circle one: Auto Accident / Worker's Compensation

Patient Information

Patient Name ____
Patient's Date of Birth ______________________________________
Home Phone: __________________ **Work Phone:** ________________

Insurance Information

Date of Accident: _______________ **Time of Accident** _____________
Insurance Company Name: _______________________________________
Insurance Company Phone Number: _______________________________
Insurance Company Billing Address: ______________________________
City: ________________________**State:** _________**Zip:** _________
Claim Number: ______________________
Adjuster's First and Last Name: __________________________________
Adjuster's Phone Number: ____
Is there an existing open file Yes / No

Auto Accident

Have you submitted the police report to your insurance company Yes / No
Have you completed your PIP application Yes / No

Worker's Compensation

Occupation: ____
Employer's Name: ____
Employer's Address: ____
City: _______________________ **State:** ________ **Zip:** ________
Employer's Phone Number: ______________________________________
Contact Name: (First and Last name): ______________________________

Patient/Guardian Signature: ___________________________ **Date:** ______

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