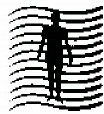

HUDSON VALLEY RADIOLOGY ASSOCIATES, P.L.L.C.

☐ MRI ☐ CIA ☐ M-H ☐ NPI ☐ KDC
☐ TLM ☐ RAMAPO ☐ OBS-GYN ☐ BERG

WORKER'S COMP. INFORMATION

Office use only MR#______________

In order for us to bill your Employer's Insurance Carrier for the Radiologist's services, we will need additional information.

PATIENT INFORMATION

Patient Name______________________________

Patient Address____

City____________________________ State__________ Zip Code______________

Social Security Number____________________________ Date of Birth__________________

Home Telephone__________________ Other Telephone____________________________

Date of Accident__________________ Last Day Worked____________________________

Onset of Symptoms Date____________

EMPLOYER INFORMATION

Employer______________________________

Employer Address____

EMPLOYER INSURANCE INFORMATION

Employer's Workers Compensation Carrier____

Address of Insurance Carrier____

Policy Number____________________________ Case Number__________________________

In the event I fail to prosecute the claim for Worker's Comp for this illness or condition or it is determined by the Worker's Comp Board that the illness or condition is not the result of a compensable Workers' Compensation case, I hereby agree to pay HUDSON VALLEY RADIOLOGY Associates, P.L.L.C. their usual and customary fees for services rendered to the above Claimant in the above identified case.

SIGNATURE______________________________ DATE______________________________