

ROC/RORS Worker's Compensation Information

Today's Date: _____

Date of Appt: _____ Time: _____ Location: _____ Provider: _____

ROC #	
Patient Name	Date of Birth
Patient Address	
Patient Phone#	Alternate #
Patient Email Address	
Date of Injury	Injured Body Part(s) (approved to treat)
Employer Company Name	Contact
Employer Address	Phone#
Work Comp Carrier	WC Claim#
Billing Address	
Adjuster	Phone#
Email Address	Fax #
Case Manager	Phone#
Email Address	Fax #
Diagnostic Imaging Vendor:	Phone#
PT/OT Vendor:	Phone#
Person Completing Form:	

I understand that per NC state law (Worker's Compensation Law, 97-27), Raleigh Orthopaedic Clinic/Raleigh Orthopaedic Rehabilitation Specialists reserves the right to send all medical information concerning my illness and treatment pertaining to the injury sustained on the job to the Worker's Compensation insurance carrier and/or my employer I understand the risk involved in faxing medical information.

DENIAL OF WORKER'S COMPENSATION

I understand that verification of my injury DOES NOT guarantee payment of my medical bill. I understand that if my employer and/or insurance company denies a claim, a copy of the denial letter shall be sent by my employer or self-insurer/insurance company to the Industrial Commission, employer, and all known medical providers as soon as an investigation is completed. Once medical providers receive a copy of the denial letter, they may bill my private health insurance or myself as dictated by state law. If I request a hearing, the provider will discontinue billing to myself until after a hearing is held and a final decision is made. However, billing to the private health insurance may continue.

Patient's Signature _____ Date _____