RALEIGH ORTHOPAEDIC CLINIC

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 #**
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#**
DME 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**_____