ROCHESTER
REGIONAL HEALTH

Return to: *Patient Financial Services*
100 Kings Highway
Rochester, NY 14617
Phone: (585) 922-1388
Fax: (585) 922-1522

Attention Workers Comp Biller

----- Patient Demographics -----

WORKERS' COMPENSATION

☐ Clifton Springs Hospital & Clinic	☐ Newark Wayne Community Hospital	☐ Rochester General Hospital	☐ United Memorial Medical Center	☐ Unity Hospital

Date: _________________ **To:** ____ **CSN:** __________________

You have been given this letter because you have sought medical care due to a work related injury which may be covered by Workers' Compensation Insurance. Provided we have the correct billing information, we will be pleased to send the bill for all services to your employer or the appropriate insurance company.

Please provide all insurance information within 10 days of date of service or you will be billed.

PATIENT PLEASE COMPLETE	
Personal Insurance Carrier	Ins. Co. Address
ID # / Group #	Ins. Co. Phone
Subscriber's Name	Effective Date

Sign below and immediately give this letter to your employer. Note that a personal health insurance will not pay for services if they are determined to be due to a work related injury. However, please provide your personal health plan in order to bill if the services are deemed not related to employment.

In the event I fail to prosecute the claim for Workers' Compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation case, I hereby agree to pay the usual and customary fees for services rendered.

Date: _______________________________ Signature: ____ Ins. Co. Address

If signed by other than claimant; print name, address, and relationship below:

Name: ____ Relationship: _____________________________

Address: ____

ASSIGNMENT

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment to Rochester Regional Health of the hospital expense benefits otherwise payable to me, but not to exceed the hospital's regular charges for this period of hospitalization. I understand that I am financially responsible to the hospital for the charges not covered by this assignment.

____ ________________________________

Signature of Patient, Parent or Guardian Date

EMPLOYER – PLEASE COMPLETE:

Employer's Name: ____ Employer Phone No.: ___________________

Employer's Address: ____

Branch store / location if applicable

Bill Employer direct, Attn: ____________________________________ Bill carrier shown below: ________________

Compensation
Insurance Carrier: ____ Insurance Carrier Phone No.: ______________

Carrier's Address: ____ Name of Claim Adjuster: _________________

____

Emp Ins. Carrier Policy No.: _________________________________ SS #/Carrier Case No.: ____________________

Date of Injury: ____________________________ Place where injury occurred: _______________________________

Employer – Please indicate above if you will pay our billing or if you want us to submit the claim to your carrier.

29456 B-46 (10/13) RETURN TO PATIENT FINANCIAL SERVICES

Downtime version - please follow downtime procedure.
Required identifiers (Name & DOB) must be on every page (both sides if two-sided form).
Use demographic labels or legibly hand-write the demographic information.