



WESTCHESTER NEUROLOGICAL CONSULTANTS

Westchester Neurological Consultants
1915 Central Park Avenue Suite 103
Yonkers New York 10710
Telephone: (914)966-0505
Fax: (914) 966-0515

WORKERS' COMPENSATION INTAKE AND AGREEMENT

I _____ agree to see the physician at the Westchester Neurological Consultants. I hereby understand that my Workers' Compensation insurance might deny coverage for these visits. I authorize Westchester Neurological Consultants to bill my health insurance plan should my workers' compensation benefit coverage be exhausted or not cover my services.

Patient/Guardian's Signature

Date Signed

WORKERS' COMPENSATION INSURANCE DETAILS

Patient's Name _____

Patient's Date of Birth _____

Social Security Number: _____

WC Insurance Name: _____

Insurance Claims Address: _____

WCB Number: _____

Carrier Case Number: _____

Adjuster Name: _____

Adjuster Phone: _____

Adjuster Fax: _____

Adjuster Email: _____

Lawyer Name: _____

Lawyer Phone: _____

Lawyer Fax: _____

Employer Name: _____

Employer Address: _____



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Health Insurance Plan: _____

Health Insurance ID: _____

Health Insurance Group: _____

INJURY DETAILS

Date of Injury _____

Injury Address _____

Employer Name _____

Job Title _____

Have you missed work due to this injury/illness? Yes No

When did you miss work? _____

Are you currently working? Yes No

When did you return to work? _____

How did the injury happen? _____

Injured Body Part: _____

Are other physicians treating this illness/injury? Yes No

List the other physicians: _____

Do you have any other workers' compensation claims? Yes No

Describe: _____

Internal Use:

Coverage Verified by: _____ Date Verified: _____

Diagnoses Covered: _____

Additional Notes: _____