



WORKERS COMPENSATION INFORMATION FORM

Please complete the form in its entirety. Failure to do so will result in the bill becoming the patient's responsibility until all of the information is received. Our staff will gladly assist you in any areas you do not understand. Thank you for your cooperation.

Patient Name: _____ D.O.B: _____

Home Phone: _____ Work Phone: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Employer Phone #: _____

Contact Name (First and Last): _____

Workman's Compensation Carrier: _____

Workman's Compensation Carrier Address: _____

Workman's Compensation Phone #: _____

Insurance Authorization # for treatment: _____

Claim #: _____

Date of Accident: _____ Time of Accident: _____

Date Authorization Obtained: _____ State the accident took place: _____

I _____ agree to pay for services provided at High Mountain Health if payment is denied for any reason.

Patient/Guardian Signature: _____ Date: _____

Wayne – Urgent Care
246 Hamburg Tpk
Ph: 973.389.1800
Fax: 973.636.2734

Wayne
468 Parish Drive
Ph: 973.305.8300
Fax: 973.305.8157

Little Falls - Pediatrics
83 Long Hill Rd
Ph: 973.785.2440
Fax: 973.785.0141

Waldwick – Urgent Care
71 Crescent Ave
Ph: 201.445.1700
Fax: 201.445.1701

Billing Department
37 Vreeland Ave, Suite 6
Ph: 973.890.2780
Fax: 973.890.8960



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High Mountain Medical Group

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