Michael E. Elia, M.D.

WP HOSPITAL physician associates

369 White Plains Road
Eastchester, N.Y. 10709
914 337-3979

WORKERS COMPENSATION INTAKE FORM

I hereby authorize payment directly to WHITE PLAINS HOSPITAL for services rendered relating to an accident/injury covered under Workers Compensation insurance benefits.

I hereby authorize the provider of these services to release any medical records relating to my claims to my insurer liable for payment of such claim.
In the event the provider's charges are outstanding and / or fail to file an application for benefits under New York State Insurance law, I understand that I am personally responsible for the payment of the charges related to my claim.

Patient's Name _____ Date of Birth _____

Address: _____ Phone # _____

Is this visit the result of an accident? At work ☐

Automobile ☐

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

EMPLOYER NAME: _____ Phone # _____

EMPLOYER ADDRESS: _____

How did accident / injury occur? _____

Body Parts established in WC Case: _____

Workers Comp Board Number _____ Carrier Case # _____

Address for insurance claims (not the agent): _____

Insurance Co Address: _____

Adjuster's Name & Phone # _____

Adjusters Fax # _____

Attorney's Name & Phone #: _____

PATIENT SIGNATURE: _____ DATE: _____

PLEASE NOTE THAT FAILURE TO PROVIDE US WITH THE APPROPRIATE CLAIM INFORMATION AND OR FAILURE TO FILE A CLAIM WITH YOUR INSURER WILL NECESSITATE US REQUIRING PAYMENT FROM YOU AT THE TIME OF SERVICE.

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NO FAULT INTAKE FORM

I hereby authorize payment directly to WHITE PLAINS HOSPITAL for services rendered relating to an accident/injury covered under NO FAULT insurance benefits.

I hereby authorize the provider of these services to release any medical records relating to my claims to my insurer liable for payment of such claim.

In the event the provider's charges are outstanding and / or fail to file an application for benefits under NO FAULT law, I understand that I am personally responsible for the payment of the charges related to my claim.

Patient's Name _____ Date of Birth _____

Address: _____ Phone # _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____AM / PM

How did accident occur? _____

CLAIM # _____ POLICY # _____

Address for insurance claims (not the agent): _____

Insurance Co Address: _____

Agent's Name & Phone # _____

Agent's Fax # _____

PATIENT SIGNATURE: _____ DATE: _____

PLEASE NOTE THAT FAILURE TO PROVIDE US WITH THE APPROPRIATE CLAIM INFORMATION AND OR FAILURE TO FILE A CLAIM WITH YOUR INSURER WILL NECESSITATE US REQUIRING PAYMENT FROM YOU AT THE TIME OF SERVICE.