Dear Patient

Thank you for choosing our Compass Medical for your Worker's Compensation or Motor Vehicle Accident related office visit today.

We understand that you may not yet have all the necessary insurance and billing information pertaining to your injury at the time of your visit today.

We will give you a copy of the Third Party Liability form that you partially filled out today. We kindly ask that you obtain the missing information needed to complete this form and return it as soon as possible in order for your claim to be processed appropriately and in a timely manner.

Without this information we cannot process the claim and you will be responsible for the services rendered pertaining to your injury.

Completed forms can be returned to the office of your visit or mailed directly to:

Compass Medical Billing Office
600 N. Bedford St
E. Bridgewater, MA 02333
508-350-2450

Thank You,

Compass Medical

DATE: ___________________________

THIRD PARTY LIABILITY FORM – WORKER'S COMPENSATION

PLEASE COMPLETE FORM AND RETURN TO THE BILLING OFFICE

PLEASE NOTE THAT IF FORM IS NOT COMPLETE AND/OR NOT RECEIVED IN BILLING WITHIN 48 HOURS, THE PATIENT WILL BE HELD LIABLE FOR ANY CHARGES RELATED TO THESE SERVICES

PATIENT INFORMATION

NAME: ______________________________ DATE OF BIRTH: ______________________________

WORKER'S COMPENSTATION INSURANCE CARRIER INFORMATION

NAME: ______________________________

ADDRESS: ______________________________

PHONE: ______________________________ FAX: ______________________________

CLAIM NUMBER: ______________________________ CLAIM REPRESENTATIVE: ______________________________

PATIENT HEALTH INSURANCE INFORMATION

PLAN NAME: ______________________________ MEMBER ID: ______________________________

ADDRESS: ______________________________

INJURY INFORMATION AND EMPLOYER INFORMATION

EMPLOYER NAME AND ADDRESS: ______________________________

EMPLOYER PHONE: ______________________________ EMPLOYER FAX: ______________________________

DATE OF INJURY: ______________________________

Brief description of how injury occurred: ______________________________

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Have you hired an attorney for this injury? ☐ YES ☐ NO

If yes, attorney's name and phone: ______________________________

Have you sought any previous treatment for this injury? ☐ YES ☐ NO

If yes, please provide the names and addresses of other providers: ______________________________

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I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS WORKERS COMPENSATION CLAIMS FOR MEDICAL BENEFITS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO COMPASS MEDICAL.

Signature______________________________ Date______________________________

Compass Medical

Third Party Liability Insurance Waiver

Today's Date: ___________________

I agree to be fully responsible for payment of any or all services rendered today at Compass Medical in the event that my employers' Workers Compensation or Motor Vehicle Insurance Carrier denies payment for any or all services rendered today pertaining to my injury.

I further acknowledge that if Compass Medical is not contracted with my private health insurance company, _______________________________, Compass Medical will be unable to bill my private insurance company for the services rendered today.

Patient Signature: _______________________________________

Print Name: ____

Date of Birth: ________________________