NYU Langone MEDICAL CENTER

Faculty Group Practice

Workers Compensation / No Fault Insurance Registration Form

__Workers Compensation __No Fault (PLEASE CHECK ONE)

PATIENT NAME: _____

NAME OF INSURANCE/COVERAGE: _____

CLAIM ADDRESS FOR INSURANCE/COVERAGE: _____

_____

_____

WCB CASE # _____ OR CLAIM # _____

CARRIER CASE # _____ OR POLICY # _____

DATE OF INJURY/ACCIDENT: _____ TIME OF INJURY: _____

CLAIM MANAGER/ADJUSTER: _____

PHONE #: _____ EXT. _____ FAX #: _____

BODY PART: _____ CURRENTLY WORKING? _____

IF YES, FULL TIME OR PART TIME? _____ IF NO, WHEN DID YOU STOP? _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

_____

_____

EMPLOYER PHONE NUMBER: _____EXT. _____FAX #_____

PLEASE EXPLAIN HOW INJURY OCCURRED: _____

_____

_____

_____

SIGNATURE: _____ DATE: _____

Revised: 1/3/2013